

**Client directed, outcome informed therapy in an intensive family
therapy unit
--A study of the use of research generated knowledge in clinical
practice**

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**To my father, Aage Sundet, war-time seaman, construction worker and wood
carver; 1920-2006**

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Abstract

This dissertation explores family therapy practice developed in a family unit within the Department of Child and Adolescent Mental Health, Norway with the aim of describing and better understanding this practice. A qualitative study was carried out in order to investigate the following research questions: (1).What are the ingredients families and their therapists identify as essential for a helpful therapeutic practice? (2). How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work? The findings of the study are connected to the following questions: (a) What happens to the forms of practice of the guiding methods of the Family Unit when they are put to use by families and therapists?; (b) What are the differences and similarities between the perspectives of the families and their therapists and how do they supplement each other?; (c) How can these measures be understood within the therapeutic context? and; (d) What is the relationship between the results of this study and results within the general field of psychotherapy research? The first three questions are addressed in the three articles and the last is the focus of this presentation of the project.

The study data are interviews of four therapists and ten families. Data were analysed using a modification of grounded theory. The analysis generated sets of categories specified by subcategories supplying answers to the two research questions. The question of what comprises helpful therapy converged on three overarching concepts: conversation, participation and relationship. The SRS and ORS were evaluated as feasible for clinical use but involved deflections and difficulties that had to be attended to in the actual clinical situation. The measures were described as conversational tools that gave rise to different conversational types and processes, an extension of their use beyond monitoring practice and supplying feedback on process and outcomes.

The three articles in this dissertation discuss what these results communicate with regard to the first three questions above. Expansions of the guiding models of practice, especially connected to the relationship between language and action and use of professional knowledge are discussed. The differences between the family and therapist perspectives also advise therapists to pay more attention to giving feedback

to families, especially on problematic or negative interaction; to the importance of structure; to the use of professional knowledge and authority and to take active part in fighting violation, disparagement and degradation. The use of tools emerges as an important aspect of therapeutic work in this study. This element can be seen as contrary to the nature of the guiding sources of the Family Unit. A perspective grounded in the work of Vygotsky and Bakhtin is suggested as a way of reconciling post modern, language oriented methods with more research based practices in which knowledge generated from patient focused research is particularly central.

This study is of a local practice. In comparison of the results of the study with findings in the field of psychotherapy in general, those that fit with the broader research field are strengthened. The primary conclusions on this topic highlight collaboration between families and their therapists. The professional knowledge of the therapists is a necessary contribution to this collaborative venture but must be constrained within a helpful therapeutic relationship. Under conditions of detrimental development and lack of change it is decisive that the therapist change. This change must be guided by prompts, ideas and the theory of change of the service users. Combining professional skills, professional knowledge and responses from the service users under the condition of no change is found to be in accordance with a radical eclectic position in which all kinds of therapeutic tools and manners of working are braided together and guided and constrained by the responses of the service users. Results that are not corroborated within the broader field invite further research. Lastly, by relating and discussing the results of this study with the broader field of psychotherapy research, a conceptualisation of psychotherapy that fits these finding is suggested. This definition underlines client resources, the therapeutic alliance, and the theory of change of the client; it highlights therapy as a process of co-evolution and collaboration; and it confirms therapy as a process in which the responsibility of therapists is to make space for, secure and strengthen both the family and the relationship with them.

Acknowledgements

As long as I have been working in mental health and even as a teenager, my interest has been in understanding psychotherapy. What is this practice that has developed over the past 125 years? Until this project, my sources of information and experience have been reading about it and doing it. The opportunity that I was given when I was offered a position as a research fellow at the University College of Buskerud (HIBU), was to find a new source for understanding this practice. Asking questions and being informed by service users and other service suppliers of this practice opened up a new avenue of knowledge. Three separate and equal perspectives and contributions that have made this dissertation possible must therefore be acknowledged: the 10 families that were interviewed, the four therapists, my colleagues who were interviewed, and my supervisor Professor Sissel Reichelt. Without their contribution this project and this dissertation could not have been realized.

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Overview of the articles

Article 1. Collaboration: Family and therapist perspectives of helpful therapy.

The article is accepted for publication in Journal of Marital and Family Therapy.

Article 2. Collaboration: Working with process and outcome.

The article is under review for Journal of Marital and Family Therapy.

Article 3. Therapeutic collaboration and formalized feedback: Using perspectives from Vygotsky and Bakhtin to shed light on practices in a family therapy unit.

The article has been accepted for publication in Clinical Child Psychology and Psychiatry

1.0 Introduction

The aim of this dissertation is to explore and understand family therapy practice developed in a family unit within The Department of Child and Adolescent Mental Health. This is a local study about a local practice in a small family unit within the Department of Child and Adolescent Psychiatry, Hospital of Buskerud in Drammen, Norway. The word ‘local’ indicates connection to *a place, to place, to locate*, a *situation* and thus to being *situated*. This dissertation has as its theme a particular place, the Family Unit, Hospital of Buskerud, where it locates a certain situation, one of problem solving and healing - a therapeutic situation. It has grown out of a need to understand this locality and what happens within it and the practices that are situated within it.

The postmodern condition (Lyotard, 1984) has been described as one in which the “grand-narratives” had broken down and “...local narratives come into prominence.” (Kvale 1992, s. 34). In this particular study, exploration of local narratives had basically to do with the needs and intentions of the participants of the Family Unit to understand the context and practice of which they were a part in order to secure a good practice with increased possibilities for accountability and transparency. The intention was one of “...developing knowledge that (was) societally located in particular societally relevant practices “ (Chaiklin, 1992, s.198); to move from a little-described practice to a “more-described-practice” in order to learn more about themselves as therapists and colleagues, and to increase the relevance of the practices within the unit for all participants, both service users and therapists. The first big question, then, was whether the practices of the unit were relevant for the involved participants: what was helpful? This question inevitably led the Unit to research and the issue of finding answers to the question of relevance. From this point, a journey was begun that involved one person from the Unit taking the role of the researcher (the author) in addition to remaining a practicing therapist. His colleagues and a group of families were invited to be informants on the issues of description and relevance of the practice.

1.1. Central Research Questions and intentions

The general aim of this dissertation has been to contribute to an evolving understanding of what psychotherapy is. This was done through an investigation of a

local practice and comparison of the findings of this study with the guiding methods of the practice under investigation, and with other findings in the field of psychotherapy research. The following research questions guided the investigation:

1. What are the ingredients families and their therapists identify as essential for a helpful practice?
2. How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work?

1.2. Psychotherapy research and evidence based practice

Part of this project has had as an implicit aim for the Family Unit to establish a concept of knowledge that suits and fits the clinical situation. Bjørkly (1996) makes a distinction between “the clinical researcher” and “the researching clinician” in which the latter position is closely connected to and constructs research questions based on actual, daily clinical practice in order to increase the relevance of results for clinicians and to bridge the gap between research and the clinic (Norcross, Beutler, and Levant, 2006). In the project reported on here, the ideal has been the researching clinician.

A journey in which scientific research is a main vehicle must also relate to the field of psychotherapy research in particular (Lambert, Garfield, & Bergin, 2004). This field is not without its problems, controversies and tensions. For instance in the mid-nineties in the Norwegian context, a debate erupted (Boland, 1997; Fyhn, 1998; Rønning, 1996, 1997a, b; Sørgaard, 1997; Vedeler, 1997). This debate concerned developments within mental health care for children and adolescents in the Northern districts of Norway concerning quality assurance (Rønning, 1996) and followed other international debates and discussions of research based practice and the researcher-clinician gap (Norcross et al., 2006).

One of the main effects of these debates was that different research positions and concepts of knowledge were put on the agenda with evidence based practice as one of the most central of these (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). The history of the concept of evidence based practice in psychology is in many ways the history of psychology as a science. Going back to Wundt and the early experimental studies, clinical psychology has a strong connection with scientific psychology (Norcross, Beutler, and Levant, 2006). When evidence based medicine was made the catchword of the 1990s (Sackett, Rosenberg, Gray, Haynes &

Richardson, 1996) it fitted with the long standing ambitions of clinical psychology to build practice on a sound evidence base. Division 12 of the American Psychological Association (APA) (Chambless, Sanderson, Shoham, Bennett Johnson, Pope, Crits-Cristoph, et al., 1996; Chambless, Baker, M. Baucom, Beutler, Calhoun, Daiuto, et al., 1998) made a strong case for the implementation of EBPs in clinical practice, but not without debate and controversy. Reed and Eisman (2006) point to the omission of "...factors related to the therapist and the nature of the treatment relationship" (p.18), as especially problematic when considering the scientific bases for psychological interventions. In the APA this has not gone uncommented. Empirically supported relationships were documented through the work of Division 29 (Norcross, 2002) and Castonguay and Beutler (2006a) seek to integrate findings from both these divisions by explicating principles of therapeutic change that work. Part of the debate can be seen to concern the idea of building a hierarchy of evidence. Certain forms of knowledge, especially those produced through clinical trials are prioritised (Bower, 2007); the effect of this prioritisation not only concerns what is explicated as best clinical practice, but reaches beyond this in the establishing of power differentials that marginalize some participants and centralize others with regard to resources for both clinical practice and research. In the subsequent debates, "...this multifaceted and complex topic has been reduced to simplistic and polarized arguments..." (Norcross, Beutler, & Levant, 2006, p. 3). An at least temporary, integrating platform seems now to have been established through the APA Presidential Task Force on Evidence-Based Practice (2006). Central in the conclusions of the Task force is the underlining of the importance of "...an appreciation of the value of multiple sources of scientific evidence. " (p. 280). With this conclusion, the notion of a hierarchy delineating best evidence seems to have been exchanged for a concept of evidence that accepts that "(m)ultiple research designs contribute to evidence-based practice, and different research designs are better suited to address different types of questions (Greenberg & Newman, 1996)" (p.274).

The study reported here is grounded in a perspective of methodological multiplicity (APA Presidential Task Force on Evidence-Based Practice, 2006; Howard, 1983). Questions of best practice and evidence based practice are connected to an assessment that goes beyond the findings of the study itself. This assessment involves comparison and relation of the results of the study to the broader methodological horizon. The results of this study will be related to the broader field

of psychotherapy research. Within this methodological horizon, the APA states that evidence involves the treatment method, the individual psychologist, the treatment relationship and the patient as "...vital contributors to the success of psychological practice" (p.275).

1.3. The inspirational sources of the Family Unit

Before the increased focus on research, the main path to clinical knowledge was through theory. Theories of psychotherapeutic practice had their origin in diverse areas of science and philosophy. The biological, psychological and social sciences were suppliers of concepts, models, theories and metaphors, and philosophical positions like existentialism, hermeneutics and positivism provided perspectives on questions of epistemology and ontology. The clinical work under investigation here is embedded in the tradition of family therapy that uses ideas, concepts and theories from systemic sciences like general systems theory, information theory, communication theory and cybernetics. The main figure here was for many years Gregory Bateson (Bateson, 1973; Hoffman, 1981, 2002). Until the mid-eighties, with some dissenters (Altman 1982; Dell, 1980, 1982; Keeney, 1982), the focus of this field followed the path of traditional positivistic research and science with emphasis on the researcher generating objective models and descriptions of the observed system. From the mid-eighties, a change occurred connected both to changes within the systemic conceptualizations and epistemological positions within the field (Sundet, 1983) and to the introduction of social constructionism (McNamee and Gergen, 1992) and post-modern and post-structuralist thinking (Flaskas, 2002). These changes led to a linguistic turn within the field. Three groups representative of this linguistic turn have been central inspirational sources for the Family Unit. These are the collaborative language systems approach of Harlene Anderson and Harry Goolishian and the Houston Galveston Institute (Anderson 1997), the reflecting team and reflecting processes work of Tom Andersen and the Tromsø-group (Andersen 1987), and the narrative practice of Michael White and the Dulwich Centre (White 1995). Common to all three approaches is a focus on collaboration and language (Andersen 1993; Anderson & Goolishian, 1988; White; 1997), and emphasis on privileging the perspectives of the service user (Andersen 1992, 1993; Anderson, 1996; Anderson, Goolishian, Pulliam, & Winderman, 1986; Epston & White, 1992; White, 1993).

1.4. Organisation of the dissertation

This dissertation is organized into six main parts. Following this introduction, the inspirational and guiding sources of the Family Unit will be presented briefly.

Thirdly, a review of psychotherapy research will be given concerning our knowledge base about the psychotherapist, the patient, theory-driven therapies, techniques, specific ingredients, common factors, children, adolescents, parents, family therapy, the therapeutic relationship, the alliance and lastly patient-focused research. These elements are identified in the literature as necessary and important within the therapeutic endeavour (APA, 2006; Castonguay and Beutler, 2006; Cooper, 2008).

The fourth section provides a presentation of the informants and the methods used in this study, and the epistemological position taken in the study. Part five summarises the results of the study through a brief presentation of the three articles that constitute it. In the final section, the results are discussed in relation to the presented literature.

In line with Lakoff and Johnson (1999) the focus will be on convergent evidence: how do the results of this study fit with the research presented in part three? This comparison will also note differences and discuss possible meaning and consequences of these differences concerning both therapeutic work and future research.

2.0. The inspirational sources

Why inspirational sources? Why not theory that is instructive for practice? In line with the perspective of Anderson (2007a) and Andersen (1997) referred to below, the term inspirational refers to the freedom to choose from any perspective, also from perspectives identified as belonging to traditions outside the identified inspirational sources. There is no loyalty to theory except the theoretical belief that what we do consists of ongoing inquiries with service users that lead to the identification of preferred actions by the participants.

2.1. Harry Goolishian, Harlene Anderson and the Houston Galveston Institute

In the beginning of the 80s, Harry Goolishian was invited to Norway by Tom Andersen, then based in Tromsø, and Einar Øritsland, head of the Christian Family Counselling Agencies in Norway. Harlene Anderson followed two years afterward and with Goolishian became a regular guest lecturer of the Norwegian family therapy community. I first met them when I was part of an Oslo based group that delivered preparatory material for a conference arranged by the Tromsø Group and Tom Andersen (Helmersen, 1988; Reichborn-Kjennerud, 1988; Sundet, 1988), the Greek Kitchen in the Arctic conference of June 1988. This conference gathered “epistemologists” such as Maturana, von Foerster, von Glazersfeldt and Bråthen, and clinicians such as Anderson, Goolishian, Boscolo, Cecchin, Flåm, Andersen and Hoffman.

In the middle of this conference, I heard Goolishian state that the time was ripe for changing the basic metaphors of family therapy from systems theory and cybernetics towards language and meaning. Instead of looking at theories of systems we should now turn our attention towards the ideas of postmodern thinking. For many of us these statements were the beginning of a new clinical era within family therapy. Although the importance of language was acknowledged within the field of systems science by Maturana and Varela (1980), the full clinical impact of this “linguistic turn” became most visible through the work of Goolishian and Anderson (Anderson and Goolishian, 1988; Goolishian and Anderson, 1987). The inspirational content of this work for the Family Unit will be given a brief presentation in the following.

Language, meaning and relationships will be used as key words to organize the inspirational ideas of the perspective taken up by the Family Unit. *Language* brings forth realities and reality is socially constructed through language. With this basic idea, clinical work is directed towards using language in new ways. To talk together, to have conversations and dialogues becomes one of the main agendas and arenas of therapy with two central positions for the therapist: that of talking and that of listening. In the first position, the use of questions has an important place. The second position underlines listening and hearing where the main processes are seen to be "...attending, interacting, and responding" (Anderson, 2007b, p. 36). For the Family Unit this has given inspiration to develop and use questions while trying to attend to, interact with and respond to the answers to these questions. Through this dual focus, the second keyword *meaning* comes to the fore. Through these conversational processes new meaning can arise; meaning is transformed and a new understanding of daily life and its problems can arise. Problems distinguish and constitute social systems; these are problem-determined systems and "...they only exist in language; they do not exist in social objectivity..." (Goolishian and Anderson, 1987, p. 4), and as such problems are not solved, they dis-solve (Anderson & Goolishian, 1988). With an increased focus on meaning, the importance of history, context, interplay and interaction between participants becomes apparent. This implies the third important keyword; *relationships*. The use of language and the creation of meaning happen in relationships and the understandings that arise are relational, that is, related to the involved persons, their histories and daily contexts of life. Relationships and being relational also imply a similarity of positions. What counts for one position can also count for the other. Family therapy has traditionally, in line with the work of Gregory Bateson (1973), described relationships through the concepts of symmetry and complementarity. In complementary relationships, the dominant behaviour of one participant elicits submissive behaviour from the other. In symmetrical relationships, the behaviour of one person elicits similar behaviours from the other. In the first instance, we see the development of increased difference that can end in separation. In the other, we see an increased similarity in the responses of each, such as in an increased escalating aggressive interchange with again separation as a result (Bateson, 1973; Carr, 2006). Watzlawick, Beavin and Jackson (1967) characterise symmetrical and complementary interactions in the following manner: symmetrical interactions are "characterized by equality and the minimization of

difference, while complementary interaction is based on the maximization of difference” (Watzlawick et al, 1967, p. 68-69). The relationship between client and therapist has traditionally been seen as a complementary relationship with the therapist in a one-up position, and difference in position is underlined more than similarity. Further, symmetrical relationships are seen as the result of reduction in difference as stated above. Difference here seems more to point towards questions of equality and power differential than mere distinction, or the difference that makes a difference (Bateson, 1980). The perspective of this dissertation is that this does not catch the fact that it is possible to have similar positions and still be different; similarity and difference are not oppositional concepts¹.

At this point it suffices to say that for Anderson and Goolishian it is important to recognise that there are huge similarities between therapists and their clients that highlight the necessity of giving equal space for the perspectives and voices of clients and at the same time recognise that there certainly also are differences between the therapist, client and family positions. This implies an increased focus on the knowledge and expertise of the Other, in addition to the traditional focus on the knowledge of the therapist. Due to the centrality of this traditional perspective, Anderson and Goolishian’s underlining of the not-knowing position can be seen as a strategy to counterweight and equalize this traditional focus with the voices of clients and service users. This is an egalitarian and anti-hierarchical view of the participants and it makes all participants partners in a collaborative venture. Listening and hearing become central parts of the therapist’s repertoire in establishing and participating in this collaboration. This also means that the participants in these relationships always have something that is uniquely theirs. From this acknowledgement comes the idea that when participating in such a collaborative venture you can never be sure of your knowledge of the other. Although the participants share many similarities there are also differences and this means that one cannot take anything for granted. Therefore the not-knowing position (Anderson, 2005) also becomes a central stance of the therapist in ensuring that difference is always related to. For the Family Unit, this stance leads directly to the stated value of always trying to be where the clients are.

Anderson (2007a) makes a distinction between a theoretical stance and a philosophical stance. Theory is seen as something that instructs practice; it tells you what to do and it can be used to justify the actions taken. “Philosophy involves

ongoing analysis, inquiry, and reflection with self and others. It is not about finding truth, scientific or otherwise, nor is it about objects or things: it is about people” (Anderson 2007a, p. 44). It is a stance that is communicated through the way therapists are towards and with their clients. Anderson refers to J. Shotter’s concept of *withness* as distinct from a manner characterised by *aboutness* (Shotter, 2004). Therapists are with their clients in their quests and actions and do not objectify clients. Knowledge is not something used on clients but rather with clients. Transparency and sharing become the backbone of a collaborative therapy.

2.2. Tom Anderson and the Tromsø-group

Andersen (1997) stated that practice comes first. Concepts and theories are effects of experiences within clinical practice. These theories can suggest future practice with the qualification that the uniqueness of future situations always opens up for change of these possible generalizations. The work of the Tromsø-group and Tom Andersen can be seen as such a quest for new understandings and conceptualizations given important changes in therapeutic practice. The traditional systemic frame was to work with a team behind a one-way mirror. At a certain point in the session, the therapists left the family and went back to the team to discuss what had happened. On the basis of this discussion a message to the family was formulated (Selvini Palazzoli, Boscolo, Cecchin and Prata, 1978). At no point was the family part of the formulation of this message. Andersen and the Tromsø group made a radical change to this format; changing the direction of sound and light in the room with the one-way mirror, they gave the family the opportunity to listen to the team discuss and reflect upon their conversation (Andersen, 1987). One can say that, for the first time in the history of family therapy, the concept of democracy became an important clinical concept in the equal opportunity for all participants to have a voice, be heard and taken into account in the clinical situation. For those in the positions of client and family, the right to make decisions about one’s own life and preferences within it became an overarching principle. Within this framework, a series of concepts and formulations by this group have inspired the Family Unit.

The concepts of difference and differences that make a difference are given a central position in this work (Bateson, 1980; Andersen, 1991). One principle at work is that when something is distinguished from its background new distinctions can be made on these. For Andersen this means that there are always possibilities for new

distinctions and differences. Whatever we distinguish and see, there is more to be seen, more differences to be distinguished. Stated differently; our distinguished descriptions of the world never include the full diversity of the world. Through language we make distinctions that bring forth aspects of this diversity and, as such, we cannot step outside language (Andersen, 2002; Sundet, 2006). This means that one always can make new distinctions; new differences that make a difference.

The next important perspective of Andersen is the existence of different differences. There are those so small that they do not make a difference and there are those so large that when meeting them “people close up...” (Andersen, 1991, p. 18). The difference that makes a difference is the one deemed “the appropriate different one” (p. 19) and this is decided by the person her- or himself. Thus the answer to what will make a difference must, in the end, be found within the life and preferences of this person. What matters is the unique situation and preferences of this person and what works for her or him. The response of the Other is always decisive for the therapist and for Andersen (1991) the protection of the integrity of the Other becomes a central agenda of therapy. A striking aspect of Andersen’s work was the manner, pace and tempo of his participation. He used the words of the person, gave her or him ample space and time, and he followed the person in all his or her movements. This has inspired the Family Unit in terms of the use of questions, according space and time to the service users and the idea of following the lead of the clients and family members. In addition, the weight placed on attempting always to respect the state, perspectives and preferences of the service users follows directly from Andersen as an inspirational source.

Andersen (2007) defines language as all communicative expressions and considers language not only a social phenomenon but a bodily one as well. We express through our body, vocally, verbally and behaviourally and we receive these expressions from others as impressions arising within us. We are moved or touched by the expressions of the other. As a bodily phenomenon, language is also an emotional phenomenon. To work with language is both to work with verbal meaning and understanding and to emotionally touch and be touched by each others’ expressions (Andersen, 1996). To participate in conversations then, is both about something and about being with someone. Andersen inspires the therapist to focus on being in language and in experiences with other persons. Participation and collaboration become experiential events. This also means that it becomes important

to know the experiences of others in their life situations to open up the context of therapy. It becomes important to work therapeutically with people in their preferred context. Therapy is moved out of the office and into the life context of the participants. This has inspired the Family Unit in working in as many different contexts as possible, only constrained by the preferences of the service users.

A main issue in the reflecting team (Andersen, 1987) and reflecting processes (Andersen, 1995) is to return a listener's response to the speaker. This response must be given in a respectful manner, banning strategizing responses where one tries to move the other in certain directions. This has inspired the Family Unit in trying to be open and transparent about one's thoughts, feelings and reactions and holding the aims and preferences of the other at the centre of these reflections. Conversations about conversations become an important way of trying to determine and stay in contact with where the Others are. This practice is a precursor for securing feedback from users through the use of standardized tools.

2.3. Michael White and the Dulwich Centre

Connected to Bateson and the systemic conceptualisation within family therapy (White, 1989a, 1989b), White, through working with children, developed a third path. With externalising the problem and the re-authoring of lives and relationships (White, 1989c), White introduced practices that allow for and increase the client's and his or her family's influence on the problem through separating persons and problems. The central idea of narrative practice is that life and the experiences of people living their lives are richer than the stories told about these people, their actions and their identities. Further, stories about people and their problems in a psychiatric context are most often formulated as pathological aspects of the person or as psychiatric diagnosis. This in turn tends to become a dominant story that excludes the aspects of life not definitional of these problems and diagnosis. The result is the production of thin descriptions of people and their lives. Through participation in conversation, and especially through the use of questions, therapists can contribute to richer and thicker descriptions that can give people access to new options for actions and identity (White, 2007).

White's work describes a change from seeing social and psychological structures (systems) as determining and causing problems to seeing the problem as causing suffering. One way of reading White is by looking into the descriptions and

specifications of forms of practice, called “maps” that he has developed. These are not theories but guidelines that can help the therapist manoeuvre without being instructed as White’s maps are pedagogical and not instructional. They suggest manners and types of questions that can be asked and, as with other types of maps, guide the user about where to move in a landscape of experience and action. They help the therapist train and prepare for such movements and allow him or her to be with and follow the client and family in their quest. These maps point to important areas that clients and therapists often encounter and can be understood as sets of suggestions for how therapists, through asking questions, can be helpful in both creating thicker descriptions and influential in helping people move from one position to another in their lives. In the following, I will give a brief presentation of these maps.

White (2007) presents maps connected to externalizing conversations, reauthoring conversations, re-membling conversations, definitional ceremonies, and scaffolding conversations. Externalizing conversations concern the idea of separating persons and problems (White, 1989c). It is not the person that is the problem; the problem is the problem. The separation of the person and the problem is confirmed by giving the problem a name that positions it as external to the person. The aim is to take a position on the problem in order not to allow it to dominate one’s life. This separation also gives the person distance to the problem and for White, this increases the possibility to stop or reduce the influence of the problem in the person’s life. In addition, by formulating the relationship between the person and the problem in this manner, it becomes possible to identify and investigate all those times the influence of the problem is reduced or the problem is not present. This is called a unique outcome that again can give opportunity for thicker or richer descriptions of persons. This perspective is the foundation for two position maps, one concerning taking a position on the problem, the other on unique outcomes (White, 2007).

Reauthoring takes as its starting point the fact that persons can be described through what they do, and what these actions speak to concerning the identities of these persons. The description of a unique outcome, an action the person takes in order not to follow the demands of the problem, can give the basis for a characterization of the identity of the person. When a person with an eating problem eats, this can be seen as an action that diverges from the demands of anorexia and can lead to a characterization of the person as, for instance, brave or steadfast. These

specified identities can again originate new actions. Reauthoring, then, concerns producing descriptions of the movement between what people do and the identities that these actions can signify.

Re-membering is the next map. It invites us to see our lives as if we are members of a club. Through questions and the telling of stories, characters both past and the present, both literal and imaginary, are brought into the conversation. As members of the same club, these are persons that have been or are important in the life of the client or who can tell important things about him or her. Through investigations of their stories, perspectives and connections with the client, richer descriptions of the client's life, identities and actions can be constructed.

Definitional ceremony is a map with a specific way of structuring conversations. The format is based on the notion of first telling a story which then is retold by a listener who again provides the origins for a new retelling by the original speaker. The retelling by the listener follows a specific structure called an outside witness response. This invites the listener to first comment on the expressions that the original story evokes in her or him, then what images these expressions lead to. The third step concerns what White (2007) calls personal resonance; "why you were so drawn to these expressions, with a specific focus on your understanding of what these expressions struck a chord with in your personal history" (p.191). The last step focuses on transport, meaning the ways the listener has been moved by what he or she has heard. Where has it brought the listener with regard to his or her thoughts, reflections and understanding concerning his or her own life? This structure focuses on acknowledgment and recognition of the service users through a specific outside witness response, and again thicker descriptions are the result.

Lastly, scaffolding questions concern situations in which people want to move from a position of the known and familiar and into areas that are unknown to them. They might want to acquire a new skill for instance. Using Vygotsky's concept of the zone of proximal development and Wood, Bruner, and Ross' (1976) metaphor of scaffolding (see article 3), White develops maps of questions that can enable people to move from the known and familiar to what is possible to know, which again can originate plans for new actions in life.

2.4. Concluding remarks concerning the inspirational sources

Although different, these three inspirational sources have a joint focus on language, stories and meaning making as basic starting points for therapy. They all value questions as a main tool and they all can be seen to give content to therapy as a collaborative venture. Meanings arise and are brought forth as a joint venture and, as such, meaning must be understood as something co-constructed. At the same time, each source acknowledges that the meaning created belongs to those who have sought our help and therefore their meanings, perspectives, preferences and values must be privileged. These commonalities together with the differences between these three perspectives are all part of the conceptual baggage of the Family Unit.

3.0. Psychotherapy research

Research on psychotherapy goes back to the early 1920s (Lambert, 2004). Since Eysenck's (1952) controversial conclusions that the psychotherapy outcome does not exceed the rate of spontaneous remission, the hunt has been on for establishing a possible empirical status of psychotherapy as a method of change and healing (Wampold, 2001). The current status of psychotherapy includes overwhelming support for its efficacy and effectiveness (Castonguay & Beutler, 2006b; Cooper, 2008; Dawes, 1994; Lambert & Ogles, 2004; Wampold 2001). In spite of this clear conclusion there are controversial issues embedded in the field of psychotherapy research. Two of these are that it is difficult to establish differential effects of different theory-driven models of psychotherapy and of therapists with different educational and professional backgrounds (Beutler, Moleiro & Talebi, 2002; Dawes, 1994; Wampold, 2001). The latter aspect seems to have gone for the most part uncommented. This author views these findings as necessitating and providing the opportunity for a revision of the concept of psychotherapy. One by-product of the study reported on here is the presentation of a definition of psychotherapy (6.0.).

Within this research field a distinction is made between process and outcome: "Process refers to what happens in psychotherapy sessions (....), whereas outcome refers to immediate or long-term changes that occur as a result of therapy (....)" (Hill & Lambert, 2004, p 84). Orlinsky, Rønnestad & Willutzki (2004) present the Generic Model of Psychotherapy as a means of understanding the concepts of process and outcome in psychotherapy. This model depicts psychotherapy process through six aspects of therapy: organizational, technical, interpersonal, intrapersonal, clinical aspects of therapy and lastly, sequential aspects of process. Outcome has also accumulated divergent meanings. Orlinsky et al (2004) make a distinction between the observational perspectives of analysis. The question of who is doing the assessment of outcome, "...patient, therapist, an expert nonparticipant, or interested laypersons, such as the patients' family" (op. cit. pp. 314) is especially important for the study presented in this dissertation. It is the aim of this study to give descriptions of process aspects that families and therapists identify as important. Part of this is the assessment of process and outcome as an aspect of process, that is; the monitoring of process and outcome as feedback to both therapists and family members as a central ingredient of treatment.

APA's Presidential Task Force (2006) points to the individual psychotherapist, the patient, the treatment relationship and the treatment method as contributors to the success of psychotherapy. In the following discussion of the research literature, conclusions within these four areas together with research on children, adolescents, parents, family therapy and patient focused research will be presented.

3.1. The psychotherapist

"Is the particular therapist important?" (Wampold, 2001, p. 185). Do therapists affect the outcome of psychotherapy? The production of answers to such questions will definitely have consequences for how psychotherapy is viewed. In the research literature the answers are not necessarily clear cut. For example, two papers in Psychotherapy Research demonstrate the difficulties that confront clinicians who seek guidance from research. Elkin, Falconnier, Martinovich and Mahoney (2006) and Kim, Wampold and Bolt (2006) analyzed the same data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program to estimate proportion of variability in outcome resulting from therapists. The interesting but troubling result was that the two analyses of the same data gave clearly divergent results. The first paper found no significant therapist effects while the second found significant therapist effects. This certainly points to the need for further research but at the same time there are indications that therapist effects must be reckoned with and also that there are differential therapist effects. Later I will present some results of patient focused research (Lambert, 2007) and one important aspect here is the documentation of differential therapist effects (Lambert & Barley, 2002). Therapists matter but some therapists matter more than others (Miller, Hubble & Duncan, 2007).

Beutler, Malik, Alimohamed, Harwood, Talebi, Noble & Wong (2004) conclude that therapist sex, age, and race are poor predictors of outcome and that therapist training, skills, experience, and style are weak contributors to outcome. They also find that any one class of interventions and techniques used by therapists has little support but that "...evidence is accumulating on the role of patient moderators in determining the effectiveness of interventions" (p. 291). Matching patient and method is therefore a topic for further investigation. Therapist positivity, friendliness, well-being and cultural values are revealed as associated with good outcome, and criticism and hostility has the opposite effect. Lastly, Beutler et al.

(2004) give attention to the therapist's contribution to the therapeutic relationship and to the therapist's model of treatment. Their conclusion is that relationship quality is one of the stronger correlates of outcome, while the specific model does not matter much. Their conclusion and recommendation is to look towards an integrative and synergistic perspective. To this end, the therapist is a central agent and critical factor in good therapy (Wampold, 2001).

Ackerman and Hilsenroth (2003) examined which personal attributes of the therapist and which techniques positively influenced the therapeutic alliance. The following attributes - being flexible, honest, respectful, trustworthy, confident, warm, interested, and open, and the following techniques-exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience were found to contribute positively to the alliance. They also found that the therapist's attributes "...may influence the development of an alliance early and late in treatment"...and "(i)f a patient believes the treatment relationship is a collaborative effort between her/himself and the therapist, s/he may be more likely to invest more in the treatment process and in turn experience greater therapeutic gain" (Ackerman and Hilsenroth, 2003, p.7). They also point out that the therapist's contributions "...to the development and maintenance of the alliance are similar to the features identified as useful in the identification and repair of rupture in the alliance" (p. 29). Repair of alliance ruptures (Safran & Muran, 2000) is seen as a central part of therapeutic processes and the actual repair and resolution of the rupture is dependent upon the therapist acknowledging and pointing out his or her contribution to and part in the rupture event. They conclude that therapist attributes and contribution must be seen in relation to what the patient brings to the relationship. "(T)he most promising strategy for future research may be to examine the interpersonal exchanges between patient and therapist that impact alliance development" (Ackerman and Hilsenroth, 2003, p.29).

This is the aim of a study by Baldwin, Wampold and Imel (2007). They separated therapist and patient variability in the alliance by differentiating between within-therapist correlations which tell how alliance is related to outcome with a given therapist, and between-therapist correlations which tell how "... therapists' average alliance is related to their average outcome (Baldwin et al, 2007, p. 843). By doing this they could also test whether there was an interaction between the patients'

and therapists' variability. They found that therapists who formed stronger alliances with their patients showed statistically significant better outcomes than therapists who did not form as strong alliances. They did not find within-therapist alliance outcome correlations, meaning that variability among patients in the alliance was not related to outcome. This points to the fact that it is not the patient who is largely responsible for the alliance and the authors conclude in the following manner:

“In situations in which therapists have trouble forming an alliance, it would behoove therapists to attend to their own contribution to the alliance and focus less on characteristics of the patient that impede the development of the alliance. Indeed, therapist attributions of resistance or maladaptive attachment styles as an explanation of a poor alliance according to our findings, would be irrelevant with regard to outcomes, although these explanations may be grist for therapeutic work” (Baldwin et al, 2007, p. 851).

What, then, about patient characteristics and attributes? Do they not matter at all? If they do, what is their relationship to outcome?

3.2. The patient

In line with Ackerman and Hilsenroth (2003) and Baldwin, Wampold and Imel (2007), Clarkin and Levy (2004) conclude that the important question is: “Which client and therapist characteristics interact most saliently and forcefully to produce symptom decline? (p.195). The classical aim of evidence-based or empirically supported treatments has been to establish a clear relationship between diagnoses and specific treatment interventions (Chambless, 1996; Chambless and Holon, 1998; Chambless, et al., 1996; Chambless, et al, 1998). The medical model (Wampold, 2001) builds directly on the idea that after a thorough assessment that results in a DSM/ICD- diagnosis, clinical trials will establish what method and theory driven package will be the best practice. Clarkin and Levy (2004) deem this an oversimplification and instead stress “...the interaction between client diagnosis and other salient client characteristics. ...” (p.214).

Duncan and Miller (2000a) assert that psychiatric diagnosis lacks both reliability and validity in addition to leading to negative side effects like attributing blame to the client. At the same time, many therapists report that a diagnosis actually reduces blame because the problems and symptoms are given an explanation that does not involve personal intentionality of the patient and/or his or her family.

Clarkin and Levy's (2004) solution is to present a broad picture of client characteristics that goes way beyond simple diagnostic classification. First they review nondiagnostic client variables that are related to specific diagnoses. This is a question of possible moderators and mediators of change. One such moderator is attributional style (see also Whisman, 1993).

Severity of symptom is the next characteristic attended to by Clarkin and Levy (2004). Lower severity is related to better outcome, higher severity to lower outcome, but they report that with more therapy sessions high severity clients improved substantially compared with a lower number of sessions. They also make a distinction between severity and functional impairment, the latter "...either results from or precedes the symptoms and provides the context for the arousal of symptoms" (Clarkin & Levy, 2004, pp.200). Symptoms may vary in severity but functional impairment for instance in interpersonal relationships may be high or low or equal for the two. Again they find that high functional impairment is predictive of lower outcome across a series of diagnoses such as depression, bulimia and others. Other client characteristics that predicted outcome across different treatments (interpersonal therapy, cognitive behavioural therapy, medication and clinical management for depression) were social and cognitive dysfunction, expectation of improvement, classification of the depression as endogenous or double, and the duration of the current episode. The presence of personality disorders was listed as a main complicating factor.

Clarkin and Levy continue to explicate sociodemographic variables such as age, gender and race, and personality variables such as expectations concerning the therapeutic work and the therapist, how prepared the client is for change and properties like ego strength and psychological mindedness. Interpersonal variables such as interpersonal relatedness, quality of object relations, attachment patterns and in-therapy behaviour are important. A consistent thread running through all of these characteristics is that therapy outcome is dependent upon a match between what the client brings and how the therapist meets this. The more rigid the therapist is with less ability to tailor treatment, the bigger the effect this may have on outcome with the risk of the client becoming cast as the problem. Clarkin and Levy (2004) state a dilemma here: "(M)any symptomatic individuals with disorders needing treatment are the same ones who have troubled interpersonal relations that may disrupt the therapeutic venture" (p. 211). Stated differently, to suffer from a personality disorder

is to suffer from a condition that strikes at the core of what is considered helpful in psychotherapy, that is; the therapeutic relationship and the alliance between patient and therapist. Friendliness, flexibility and being genuine as a person seem a better way of entering such a situation than rigid methodological and confrontational manners of working.

We see that a set of characteristics, here patient characteristics, must be seen in relation to the persons with whom one enters into interaction. A recurring theme in this dissertation is the question of collaboration, how to establish it, how to maintain it, what to do when it does not function and where to put responsibility for what in establishing a therapeutic collaboration. In this regard, it is also important to discuss how techniques relate to the process and outcome of therapy.

3.3. Theory driven therapies, techniques, specific ingredients and common factors

As stated above, psychotherapy is efficacious and effective (Cooper, 2008, Lambert, 2004). About the differential effects of manual based therapies the conclusion in the literature is that “(d)ecades of research have not produced support for one superior treatment or set of techniques for specific disorders” (Lambert & Ogles, 2004, p.167). Instead:

“It is possible that too much energy is being devoted to technique studies at the expense of examining therapists as persons and in interaction with techniques, as well as patient characteristics.....Such studies may well show not only potent therapist outcome but also that technique differences are inseparably bound with therapist and patient differences” (p.169).

One question here may be what to give the main weight of attention; therapist-patient interactions or the interaction between therapeutic procedures and patient characteristics. Beutler, Moleiro and Talebi (2002) state that when comparing theory driven, manualized therapies applied to specific diagnostic groups “...there is very little evidence that the effects of different psychotherapy procedures are specific to the various symptoms that define a diagnosis” (p.139). For them it is unwise to think that effective methods are all part of one single theory and that a single diagnosis can capture the qualities that “constitute motivation, prognosis, and progress...”(p.139). These conclusions lead to the question of how classes of treatment procedures, rather than brand names, interact with qualities of patients. Castonguay and Beutler (2006a)

follow this line and report on therapeutic principles that work. Lambert and Ogles (2004) do not dismiss the effect of techniques and follow the idea of "...carefully matching techniques to client dispositions, personality traits, and other diagnostic differences" (p. 180). There are undoubtedly interpersonal, social and affective factors that are common across different therapies. Common factors and the Dodo-bird verdict (Wampold, 2001) must be taken into account but at the same time they are in need of being understood. What does it mean when a factor is classified and named as "common"?

"The aim of common factors is to determine the core ingredients that different therapies share, with the eventual goal of creating more parsimonious and efficacious treatments based on those communalities "(Norcross, 1999, p. xviii).

Common factors are differentiated from specific ingredients, with the term "specific" defined as "a term ubiquitously used to refer to theoretically derived actions..."(Wampold, 2001, p. 5). Common factors are also referred to as incidental, meaning that they are not characteristic of a theory. One possible misunderstanding that can arise is that common factors may be understood as "general" in opposition to "specific" meaning concrete and delimited. Common factors are just as concrete and delimited as specific factors, for instance the communication of respect is just as concrete as a psycho-dynamically oriented relational interpretation, but is not related to theory in the same manner. Strupp (1986) states that; "...interpersonal variables such as empathy, warmth, and caring should be regarded as specific as traditional techniques" (p.513). In the same manner incidental does not mean haphazard but rather not systematically connected to a specific theory, although haphazard events may also be common factors. Not being haphazard means that common factors as used by therapists are connected to some beliefs, assumptions or model about therapy and change without necessarily being identified as related to a specific, delimited theory. Perhaps one should talk about "theory specific factors" and "common specific factors" instead of specific and common factors to underline the concreteness of both types of factors.

Building on and extending Lambert's (1992) four therapeutic factors – extratherapeutic, common factors, expectancy or placebo, and techniques -- Hubble, Duncan and Miller (1999b) suggest four groups of common factors: extra-therapeutic factors, relationship factors, placebo, hope and expectancy and model/technique

factors. With this classification the possibility emerges that there may be factors concerning the client and his or her life context, the relationship between client and therapist, the hopes and expectancies of the participants and the model and techniques used that cut across all efficacious and effective therapies. This means that whether theory specific or not, models and techniques must be investigated and taken into account.

Holan and Beck (2004) find strong support for cognitive behaviour therapies and Elliott, Greenberg and Lietaer (2004) for experiential therapies, but again the problem is to establish strong support for differential effects. Elliott et al (2004) found that when allegiance effects were taken into account small differences between CBT and experiential therapies disappeared and treatment equivalence was concluded.

Emmelkamp (2004) states that it is “becoming increasingly clear that the quality of the therapeutic relationship may be influential in determining the success or failure of behavioural therapies, although well-controlled studies in this area are rare” (p.431). Within the cognitive therapies, Gilbert and Leahy (2007) state that the therapeutic relationship do become important for several reasons. The importance of feeling safe for the patient through a “containing relationship” is one aspect, but also we know that relationships can influence psychological and physiological processes in a powerful manner, and can be an arena both for problems and amelioration. The relationship is also an arena for thinking and reflection upon the participants’ lives and experiences.

Lambert and Ogles (2004) conclude that “there are probably some specific technique effects as well as large common effects across treatments...” (p.180). It therefore seems a sound strategy to keep in mind both common factor and specific effects while not feeling obliged to choose a specific theory driven method. An eclectic orientation seems just as viable when combining both common and specific factors.

3.4. Children, adolescents, parents and family therapy

The review and conclusions presented above are mostly taken from research with adults in individual therapy. What about children, adolescents and their parents, especially in a family therapy context?

Burns, Hoagwood, and Mrazek (1999) report strong evidence for five forms of services and treatments for children and adolescents: “...home-based services,

therapeutic foster-care, some forms of case-management and both pharmaceutical and psychosocial treatments, for specific syndromes” (p.238). Within psychosocial treatments they report a strong evidence base for those who focus on parent management training, problem-solving strategies, and parent-child interpersonal skills...”(p. 238). They also conclude that the effectiveness of the service does not have as much to do with the type of service as with how, when, and why families are engaged. “Family engagement is a key component not only of participation in care, but also in the effective implementation of it” (p. 238). Coupled with this is the underlining of a trend in which one is moving away from a hierarchical, top-down manner of service delivery towards service delivery with a much closer and collaborative relationship between caregivers and therapists (Burns, et al., 1999).

Shirk and Russell (1996) underline the lack of connection between research and child psychotherapy concerning research on development and change processes in childhood and on the processes and outcome of psychotherapy. Giving a chronological review of research on psychotherapy with children and adolescents they show a history that in many ways mirrors the history of adult psychotherapy but with a clear conclusion that the methodological qualities of the studies with children and adolescents seem more problematic than those with adults. Research on children and adolescents was reported to lag behind in methodological quality. In addition, they strongly point out “...that the problem with the traditional approach, that is, matching treatment brands with diagnostic entities, is that it fails to conceptualize both treatment and disorders in terms of component psychological processes” (Shirk & Russell, 1996, p. 88). Their view is that the task at hand is to identify the psychological processes “...that constitute both therapeutic interventions and variations in childhood maladjustment” (p. 88).

Kazdin (2004) seems to have a slightly more optimistic view of the methodological situation. In a review of meta-analysis he follows Shirk and Russell (1996) in concluding that psychotherapy appears to be better than no treatment, and that “...the magnitude of the effects with children and adolescents closely parallels the magnitude obtained with adults” (Kazdin, 2004, p. 551). Less consistently, other conclusions from the field are that when differences in effect are detected these favour behavioural techniques, the effects are maintained from post treatment to follow up, treatments are more effective with adolescents than with children,

individual therapy is more effective than group therapy and treatment is equally effective for externalising and internalising problems (Kazdin,2004).

Miller, Wampold, and Varhely (2008) conducted a meta-analysis in order to determine whether there were differences in efficacy among treatments applied to youth. Their conclusion was that differential effects found were explained by allegiance effects:

“Controlling for allegiance of the researcher to the treatment approach under investigation removed all variability among the effects. In other words, allegiance explained all the observed systematic differences among treatments...the results are generally consistent with the dodo bird verdict, when allegiance is controlled for” (Miller, et al., 2008, p. 7.)

Shirk and Russell (1996) give close attention to the therapeutic relationship and the working alliance. Kazdin (2004) explicitly recognizes the parallel development of research on adults and children, and Kazdin and Nock (2003) recommend that formal evaluation of the alliance be included in research on change in child and adolescent therapy. Green (2006) acknowledges that research on the therapeutic alliance has been a neglected area within child mental health treatment studies. In Kazdin, Whitley, and Marciano (2006) full focus is directed towards the therapeutic alliance in evidence-based treatment for children and the authors conclude that both child-therapist and parent-therapist alliance predicted outcome. Shirk and Russell (1996) raise the discussion about how to look upon and understand the therapeutic relationship. They point to different ways of viewing this relationship; either as a means to and end or as an end in itself.

There are clear conclusions about the importance of the therapeutic alliance in working therapeutically with children and adolescents. Shirk and Karver (2003) found a small but reliable relationship with outcome, and Karver, Handelsman, Fields and Bickman (2006) showed a small to moderate relationship with treatment outcome. Karver, Shirk, Handelsman, Fields, Crisp, Gudmundsen, et al., (2008) found a strong association between the therapeutic alliance and client involvement and that involvement was “...differently related to treatment outcome, depending on treatment type” (p.23). In their conclusions they underline that “(t)herapist lapses, such as failure to attend to and acknowledge adolescent emotional expressions, appear to have a deleterious effect on alliance formation across types of treatment”

(p.25). At the same time their results indicate that "...common factors may not be common across all types of treatments and that there may be variations in effective relationship factors depending on the specific therapeutic techniques or orientation of the therapist" (p. 25). Concerning the question of whether one should have a focus on empirically supported techniques or relationship factors, their conclusion is that "...further research should look at how empirically supported relationship techniques and relationship factors both may influence effectiveness in different approaches to treating mental health problems" (p. 25).

Sexton, Alexander, and Mease (2004) focus on mechanisms of change. They conclude that the ability to help families redefine their problem mediated treatment effects together with changing the families' manner of problem solving when meeting impasses, reducing negativity and improving communication. In addition, the therapeutic alliance and early structuring of treatment sessions were important mediators of outcome (Sexton, Alexander, and Mease, 2004). Again the therapeutic alliance emerges as an important part of the therapeutic work and process. Friedlander, Escudero, and Hetherington (2006) introduce a trans-theoretical model for the therapeutic alliance in conjoint therapy and state that "... (i)n virtually every account of common factors and principles of change, the working alliance between therapist and the client takes center stage" (p. 4). So far in this investigation of therapeutic factors related to all age groups, the therapeutic alliance appears central.

3.5. Patient focused research

Howard, Moras, Brill, Martinovich and Lutz (1996) state that there are "...three fundamental questions that can be asked about any treatment (intervention): (a) Does it work under special experimental conditions? (b) does it work in practice? and (c) is it working for this patient?" (p.1059). For the clinician facing an actual patient, it is the third question that is crucial and in need of immediate answer. This means that "...one critically important task of research is to provide valid methods for systematically evaluating a patient's condition in terms of the ongoing response of that condition over course of treatment" (p.1060). This is the basis for patient-focused research (Howard, et al., 1996). This means systematically monitoring patient responses to treatment during the course of therapy and making this information available to the therapist. This requires regular measurement of outcome (Johnson and Shaha, 1996) through the use of a standardized measure continuously

throughout the therapeutic work (Lambert and Brown, 1996). Compared with questions (a) and (b) above this involves going beyond pre- and post-treatment assessment of the treatment (Kadera, Lambert & Andrews, 1996).

A series of experiments have investigated the effects of continuous monitoring and the use of such information as feedback (Harmon, Lambert, Smart, Hawkins, Nielsen, Slade and Lutz, 2007; Hawkins, Lambert, Vermeersch, Slade and Tuttle, 2004; Lambert, Whipple, Smart, Vermeersch, Nielsen and Hawkins, 2001; Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen, et al., 2002; Whipple, Lambert, Vermeersch, Smart, Nielsen and Hawkins, 2003). In Lambert et al. (2001) the question under study was whether feedback on patient progress improved outcome. This was studied by "...supplying therapists with feedback about patient improvement through the use of progress graphs, as well as warnings for patients who were failing to make the expected degree of progress" (Lambert et al, 2001, p.. 51). A clinical trial was set up in which the feedback to the experimental group was formulated as progress graphs, coloured dots, and a statement that corresponded to each dot. Red, yellow, white or green corresponded to deterioration, no change, progress and recovery respectively (Lambert et al., 2001). Four treatment conditions were set up: (1) patients with green or white dots with therapists receiving feedback, (2) patients without therapists receiving feedback, (3) those with yellow or red with therapists receiving feedback, and (4) those without therapists receiving feedback. The patients in the two latter conditions were labelled not-on-track cases (NOT) (Lambert et al., 2001). NOT cases are connected to the fact that 5-10 % of the participants in psychotherapy deteriorate during treatment (Lambert & Ogles, 2004).

The results confirmed that the average outcome for not-on-track cases whose therapists received feedback was better than the average outcome for not-on-track cases receiving no such feedback. Also, fewer of the not-on-track cases with feedback "...were rated as deteriorated at the end of therapy, while more were rated as having reliable or clinically significant improvement" (Lambert et al, 2001, p. 63). The study also shows that the average outcome for most not-on-track cases with feedback was classified as "no change" or "deteriorated" which means that a large number of cases did not attain a clinically significant change. The authors suggest a "need to increase the strength of the feedback manipulation or to link feedback more closely to other quality improvement efforts in future research" (p. 64). In later

studies this was tested through the introduction of clinical support tools (CST) (Whipple et al. 2003).

A study by Whipple et al., (2003) investigated whether more not-on-track cases could have an enhanced outcome by linking feedback to the use of CST. These tools helped the therapists assess "...the quality of the therapeutic relationship, client motivation to change and its match to treatment tactics, the client's social support network, accuracy of the diagnostic formulation, and the appropriateness of a referral for medication" (Whipple et al., 2003, p. 60). The results supported the conclusion that the use of CSTs enhanced improvement of similar clients whose therapists received feedback but did not use CSTs.

A study by Hawkins et al (2004) investigated whether there was difference in outcome when providing information on progress to both therapists and patients in contrast to treatment as usual (TAU). Patients in the feedback condition were significantly more improved at termination than those in a treatment as usual condition, and a large percentage of patients in the patient-therapist feedback group met clinically significant criteria.

The above research points to the use of feedback, at least to the therapist, as helpful, and suggests that reviewing feedback about NOT cases and the use and implementation of CST enhance the outcome. Practice built on this research opens up for the possibility of evaluating the practice of each therapist. However ... "(e)valuations in this context are much more threatening than studies that focus on comparison between theory-based interventions"(Lambert, et al, 2004, p. 813). This means that for the psychotherapy professions, an important change is about to take place. The effects of one's own professional practice and skills becomes a central target area for both research and practice.

3.6. The therapeutic relationship and the alliance

Running through the above review of research is the therapeutic relationship and the therapeutic alliance. Patient focused research adds to the significance of therapists having to take feedback seriously and change their focus in therapy in order to both strengthen the alliance and change their practice. In their review of the concept of the alliance, Horvath and Bedi (2002) argue that collaboration and consensus are the most important and distinguishing features of the therapeutic alliance. Bordin's (1979) formulation of the therapeutic alliance consists of three elements; agreement

on goals, consensus on tasks and a bond between the client and therapists. These become central elements in a "...modern alliance theory emphasizing the active collaboration between the participants" (Horvath & Bedi, 2002, p. 39). Their definition is as follows:

"The alliance refers to the quality and strength of the collaborative relationship between client and therapist in therapy" (Horvath & Bedi, 2002, p. 41).

Positive affective bonds between client and therapist, consensus and active commitment to goals and means, a sense of partnership and of the alliance as a conscious and purposeful aspect of the relation between client and therapist are specifications of this definition. This represents a move away from underlining the unconscious aspects of the relationship toward a more equal and cognitively oriented perspective on the alliance.

Tryon and Winograd (2002) reviewed research on goal consensus: "the therapist-patient agreement on therapy goals and expectations" (p. 109), and collaborative involvement;" the mutual involvement of patient and therapist in a helping relationship" (p. 109) in relation to engagement; "the initial involvement of patient and therapist in the therapeutic process" (p. 109), and outcome. Six of nine studies showed a positive association between goal consensus and engagement, and in 19 of 24 studies collaborative involvement was positively associated with engagement. In relation to outcome, the research tended to support the positive influence of goal consensus and collaborative involvement. In particular, collaborative involvement is underlined as enhancing outcome while the positive relationship between goal consensus and outcome was not as strong, possibly due to the fact that although there was a sharing of goals, the manner of talking about them was different and as such difficult to assess. The clinical suggestions of Tryon and Winograd (2002) point to the fact that patients assessed as easy to collaborate with are easier to engage and establish both goal consensus and collaboration with. The mirror image of this would be that therapists who are able to collaborate with their patients are potentially more helpful. Tryon and Winograd state that when therapists attend to patient problems, help patients to clarify concerns, address topics of importance to their patients and resonate to patients' attributions of blame regarding their problems, patient engagement increases and therapeutic collaboration arises.

Goal consensus and collaboration are identified here as clear therapist responsibilities and part of what therapists must establish skills and knowledge in. This is supported by the study by Baldwin, Wampold and Imel's (2007) cited above which concluded that the therapist must have interpersonal skills facilitating the establishment of shared decision making with frequent discussions of goals. Where clients do not match the collaborative invitations of the therapists this is a clinical problem best solved by looking at the therapist rather than patient characteristics.

Testing out a theoretical model, Karver, et al. (2006) also found alliance to be a robust predictor of treatment outcome, but pointed to a more complicated picture concerning youth and families. A moderate to large relationship with treatment outcome was found for therapist direct-influence skills and the therapeutic relationship with youth. Counsellor interpersonal skills, parent willingness to participate in treatment, youth willingness to participate in treatment, client participation in treatment, and parent participation in treatment were only moderately related to treatment outcome. In addition, the therapeutic alliance with the family, therapeutic alliance with youth, relationship with parents, and autonomy demonstrated a small to moderate relationship with outcome. Their model suggests interaction effects between the different relationship constructs. They give the following example:

...therapist characteristics and behaviours influencing client's cognitive, affective, and behavioural reactions to the therapist and therapy and client's cognitive and affective reactions to the therapist and therapy influencing actual participation in treatment" (p. 60).

Here a complex picture emerges in which the relationship between constructs such as therapeutic relationship, alliance and collaboration and outcome is related to interactions between aspects of the therapist, the client, and techniques used. In family therapy, this complexity increases because of the possibility of multiple alliance constellations between each family member and the therapist(s) (Friedlander et al., 2006) and within the family where "split" alliance between family members is related to outcome (Friedlander, Lambert, Escudero, and Cragun, 2008). The concept of tailoring treatment (Norcross, 2002b) becomes a particularly relevant metaphor for this complex interaction. This raises the question of whether such tailoring actually is realized. So far, in this presentation of research, the focus has been on efficacy and effectiveness research documenting results at the group level. When tailoring

treatment becomes the agenda, a need for knowledge about the individual level becomes visible: “Can I tailor the treatment to this client sitting in front of me?” No group level research can answer this question. This is the concern of the patient focused research presented above.

3.7. Concluding remarks concerning psychotherapy research

Interpreting the reviewed literature leads first of all to a confirmation of the importance of the therapeutic relationship and especially the therapeutic alliance. An emotional bond characterized by respect, empathy and listening is central. Agreement on goals, goal consensus, and method and manner of working together; that is collaboration between service users or therapist, is a necessary ingredient. How the therapist is in the relationship also matters. When there are ruptures or difficulties in establishing an alliance achieving one is the responsibility of the therapist. What characterises the client also matters, especially in how the therapist meets and organizes the therapeutic work. High severity and functional impairment speak to how much therapy is needed and when there are complicating factors like personality disorder, a low confrontational style with high flexibility is clearly indicated. The big question seems to be how much it matters what therapists do. What part does technique and manners of working play in the outcome of psychotherapy? Theory driven methods are deemed efficacious, but it is not understood if this points to specific factors or common factors. At the same time there are clear indications that therapy should be tailored to individual clients and thus a conclusion would be that it matters what is being done. Tailoring means that different clients profit from different manners of working and also that therapists may need to be in different modes when relating to different clients. The intertwining of being and doing becomes important. Perhaps any “doing” may fit the client and not specific ingredients based on specific theories. These conclusions also seem to hold for children, adolescents and families although with possible modifications of the alliance concerning children and adolescents. A main point that can be drawn from these conclusions is that the therapeutic work needs to be continuously monitored. The results must be fed back to at least the therapists and changes must be initiated by the therapist as a response to this feedback.

4.0 Method and Material

The aim of this study was to explicate the thinking of families and therapists about therapeutic practice, both in general and specifically concerning the use of process and outcome monitoring through the use of two measures, the Session Rating Scale and the Outcome Rating Scale (Duncan, Miller, Sparks, Claud, Reynolds, Brown et al., 2003). This meant application of a method that was specifically directed at accessing and using the verbal report and descriptions of family members and therapists. Part of this project also was to investigate the possibilities and problems around studying one's own practice. In this study this meant that one of the therapists (the author) took the role of "the researching clinician" who is concerned with clinical issues and problems as "...he/ she sees it from a practically constrained research position" (Bjørkly, 1996, p. 343, *my translation*). In contrast to this position there is "the clinical researcher" who traditionally has been the one setting the research agenda in the clinical domain. There does not have to be an opposition between these two positions but there remain concerns about the researcher-clinician gap and that research based knowledge does not easily spread to clinicians (Weisz & Addis, 2006). The notion of the researching clinician can be seen as an attempt to bridge this gap. For this particular study, this involved making specific demands of the method used. It should be applicable to verbal material and it should be useable by only one researcher. This led the attention of this researcher towards qualitative research and Grounded Theory (Glaser, & Strauss, 1968) and applications of this method within psychology, especially the work of David Rennie (1994a, 1994b, 1998, 2000, 2006, 2007; Rennie and Brewer, 1987; Rennie, Philips and Quartaro, 1988).

4.1. Methodical hermeneutics

As will be shown below the method used for analyzing the data of this study is a mixture of elements from methodical hermeneutics (Rennie, 2000) and consensual qualitative research (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005, Hill, Thompson, & Williams, 1997), although the former has the main focus. Rennie (2000) uses the following definition of hermeneutics as a "theory of the operation of understanding in its relation to the interpretation of texts" (Ricoeur, 1978, p. 141). The operation of understanding can be seen to involve processes of inquiry and meaning making. Inquiry and meaning making are recognized as being done from

different perspectives and as such involve interpretation (Rennie, 2000). Rennie (2007) locates methodical hermeneutics within an epistemology that accommodates both realism and relativism. He points out that natural science ends up reducing the person downwards; that is, to categories from another descriptive level than the personal, while within the human sciences, such as in constructionist positions, the tendency is one of an upward reduction of the person to “language, culture, and/or tradition...” (Rennie, 2007, p. 10). By keeping the person in the centre, realism and relativism is both included and balanced. On the one hand realism is accommodated by grounding the categories created in the data generated, and on the other hand the interpretation of these data is acknowledged as part of the researcher’s perspective. Two operations are central here: first, the operation of constant comparison, and second, the operation of reflexivity. The purpose of constant comparison is to “discourage the analyst from making subjective the understanding of the text by importing a priori, rationally derived understandings” (Rennie, 2000, p. 485). It “grounds” or keeps the analysis connected to the data and as such the meaning generated is not haphazard or simply constructed by the analyst. It is realistically connected to the material produced by the investigated person. At the same time, the researcher or analyst is not kept out of the material. He or she works “with their own experience when attempting to understand the experience of others...(Rennie, 2000, p. 487). Rennie (1995) suggests a *plausible constructionism* characterized by a rigor that “...rests on the extent to which the human scientist manages to address adequately the construction of two components—the realism of the object under study and the relativism of the researcher’s subjectivity” (Rennie, 1995, p. 46). The last entails a reflexivity that implies a subjective involvement “...in the object and representing the returns from that activity” (p. 47). This reflexivity means to show and clarify the position and perspectives of the researcher while acknowledging that these cannot be kept out in the classical sense of bracketing (Giorgi & Giorgi, 2003). Instead, one could talk about a co-construction between researcher and person or object under investigation where the presuppositions and perspectives of the researcher help draw out and direct attention to specific parts or aspects of the data under analysis. Central here is that the researcher makes the conscientious effort to be self-reflective and to express the returns from the reflexivity (Rennie, 1995). In the following, this will be done by following the recommendations of Elliott, Fischer

and Rennie (1999) for increasing the quality of qualitative research (Appendix 1, table 8).

4.2. The researching clinician

Following methodical hermeneutics (Rennie 2000, 1998) and the recommendation of Elliott, Fischer and Rennie (1999), perspectives and presuppositions of the author and researcher of this study will be presented.

First of all, I am very comfortable with the designation “researching clinician” (Bjørkly, 1996). I identify myself primarily as a clinician and I want to do research from this position. This means that when I cross the bridge over the clinician-researcher gap I bring with me loyalties, perspectives, ideas and understandings formed through 25 years of working as a clinical psychologist within mental health of children, adolescents and adults. These loyalties have primarily been to the field of family therapy both as a practice of treatment and as a theoretical, philosophical and research based field.

I started out as a student by criticizing the scientific fundament of family therapy (Sundet, 1983) and found that working with this critique gradually brought me closer to the field and eventually engulfed me and my interests. I have been interested in the aspect of family therapy history connected to the work of Gregory Bateson. In the eighties, I was very influenced by the epistemology-debate as it was brought forth by authors like Allman (1982), Dell (1982) and Keeney (1982). Ideas from the cybernetics of cybernetics or second order cybernetics (von Foerster, 1977) and structure determinism (Maturana and Varela, 1980) became particularly influential because they led to a connection with postmodern and poststructuralist ideas. At the same time, within my clinical practice I experienced that the help these ideas gave me was only partial and sometimes experienced as completely irrelevant to the tasks I met in my clinic. As the family therapy field began to be drawn to ideas about language and “the linguistic turn” in philosophy (Flaskas, 2002), I was working with children and adolescents in a team focused on emergency cases. Here I came in contact with boys ages 12 to 18 with at least one common trait. They were not fond of talking about problems, they were often assessed as unmotivated and today they probably would easily be diagnosed as having problems with reflective functioning and mentalization (Fonagy, Gergely, Jurist, & Target, 2004), or at least they were experienced as not using language in the reflective manner in which the field of

family therapy was more and more interested. I experienced that with these boys “doing” was more important than “talking”, closeness more important than distance and mutual participation and sharing of activities a more important agenda in the therapy room than talking and meaning making. These experiences led to an interest in developmental psychology and using the formulations of Daniel Stern (1985) as metaphors for psychotherapy with children and adolescents (Sundet, 2004a).

Stern gives an elaborate description of the relationship and nonverbal turn taking between child and care taker through concepts of regulation, agency and intersubjectivity. These concepts and formulations give an opportunity to downgrade the importance of language in psychotherapy and upgrade interaction and mutual participation. Clinically, this leads to a practice fuelled by the idea that the therapist can do anything, within ethical boundaries, to establish turn taking with clients. Turn taking becomes the foundation and start point for therapeutic work which can be nonverbal and action oriented just as much as language and conversation oriented, and results in the perspective that psychotherapy consists of two sets of processes; one called *participation*, the other *reflection* (Sundet, 2004, a, b. c.). The importance for this study is that I entered this project with an affinity for participatory, nonverbally oriented clinical work within an eclectic orientation, and in order to establish such turn taking, following the client was a necessary principle. This led me to seek employment at the Family Unit because I knew that this was a common clinical platform we shared and that I wanted to develop and investigate further. The above description of history and clinical preferences and interests provides important insight into how the data have been read and attended to by the researching clinician in this study. This process of interpretation will be given further explication below.

4.3. The Context

The physical context of this study is a combined day treatment and outpatient unit, the Family Unit, within Child and Adolescent Mental Health in Norway. It has existed for 12 years and at time of writing, six therapists service the practice. The therapist group consists of highly experienced therapists with backgrounds in diverse areas of practice within mental health and social welfare, and with varied professional backgroundsⁱⁱ in different therapeutic methods.

In addition to its physical and organisational location within the hospital, the Family Unit is located within historical traditions of mental health care and

psychotherapy, especially family therapy. The inspirational sources presented above are representative of this context. In addition, the Family Unit became inspired by the work of the Institute for the Study of Therapeutic Change (Duncan & Miller, 2000a; Hubble, Duncan, & Miller, 1999a; Miller, Duncan, & Hubble, 1997) and decided in 2001 to implement a practice for increasing accountability and quality assurance by incorporating the use of two measures for monitoring process and outcome, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) (Duncan, 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003). In line with the inspirational sources of family therapy, this practice was seen to fit with the general idea of “following the client”, a founding idea for this unit (Sundet & Øritsland, 2006; Øritsland, 2003).

4.4. The Study

A research project was initiated in 2004 in order to explore characteristics of the practice and experiences of the participants (both therapists and service users) within the practice of the Family Unit.

The research questions investigated are as follows:

1. What are the ingredients families and their therapists identify as essential for a helpful therapeutic practice?
2. How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work?

In addition to the above specified research questions there was the pragmatic aim of obtaining experience and knowledge about doing research on a practice of which the researcher clinician himself was a part. In order to bridge the gap between research and the clinic, the presupposition of this study was that the clinician must achieve first hand knowledge about what research means and at the same time be alert in looking for the distinctive features of the practice under investigation.

4.5. The participants

Four therapists (appendix 1, table 1) and ten families, ten mothers, six fathers and eleven children in total thirty persons, were interviewed (Appendix 1, table 2). In addition to written information the therapists received personal information about the development of the project through the ordinary meeting points of the unit. This

provided potential participants with opportunities for giving responses to the themes, method and aims of the study.

The families were recruited by the therapists and were given both written and oral information about the study (appendix 2). All the families asked except one, who could not find a suitable time, said yes to participation in the project. When a positive response was given to the therapists, the researcher contacted the family and an appointment for the interview was made. The following criteria were used for selecting families for the project:

1. Both families that were in active treatment and families that had finished the treatment.
2. Both single-parent and two-parent families.
3. Both families that the therapists experienced and assessed as being helped at the moment of contact and families that were not being helped.

The last criterion was a subjective assessment undertaken by the therapists. After the analysis the researcher made an assessment based on statements in the interviews of whether the family was being helped and experiencing the treatment as useful or not, and whether or not the family was uncertain or ambivalent on this question (appendix 1, table 3). 7 families were evaluated by the researcher as having been helped and experienced the treatment as useful. For two families, this was not the case. One family reported an uncertain result with ambivalence towards how much the family was helped. Here it was reported that both helpful and non-helpful aspects were present.

Concerning SRS and ORS both families that were assessed by their therapists to experience these measures as useful and families who did not was sought included (appendix 1, table 3). Again, seven families were assessed by the researcher to report that the SRS and ORS were helpful and useful. One family stated that the measures were not helpful and they had refused to use them. Two families were ambivalent with regard to their usefulness. They had again experienced both useful and not useful aspects of these measures.

In addition to the above mentioned criteria of selection, when the families were contacted on the phone by the researcher, the parents were given the choice of an individual interview or an interview as a family. In addition, they were asked if they wanted their children present, and if so, the parents asked them to join. Most of the families chose a family interview except one in which only the mother wanted to

participate, not the father and child. In one family, circumstances prohibited the participation of the children, and one mother did not want her child to participate. In seven of the families, the children were present. The participation of the children varied from active participation in the interview to commenting only when feeling for it and leaving the main part of the interview to their parents.

4.6. Data collection

When they met up for the interview the family members were given a declaration of consent to sign (Appendix 3). The participants were then interviewed for 1½ hours. Interview guides were prepared for both the therapists, parents and children/adolescents (appendix 4). These guides functioned as thematic guidelines for the interviews which were conducted using open-ended questions (Kvale, 1996) as starting points for conversations. These conversations were focused on the two main areas of the investigation; what is helpful therapy and how do families describe and evaluate the use of the SRS and ORS, at the same time allowing both therapists and family members to follow the associations and thoughts evoked by these conversations. As such, the interview guides functioned as a memory tool for the interviewer in helping him assess whether all aspects of the investigated questions had been covered. The interviews were audio taped and transcribed by a professional transcriber and analyzed by the author.

4.7. The analysis

When confronted with choice of method, the researcher identified two extensions of grounded theory as particularly relevant: methodological hermeneutics (Rennie, 2000; Rennie et al. 1988) and consensual qualitative research (Hill et al, 1997). Different aspects of both these groups' thinking and descriptions were appealing to this researcher. Rennie (1994a) states:

“The framework of grounded analysis allows for the development of particular procedures according to the preferences and circumstances of the individual researcher p. 236).

Taking this as an invitation to tailor the research method to the particular study, the researcher made the decision to use elements from both these methods in producing a method that fit this project. In the following presentation, the choices of different methodological elements and their stated reasons will be clarified:

1. Grounded theory (Glaser & Strauss, 1968) employs theoretical sampling, what Rennie et al. (1988) name theory-based data selection. This involves the selection of new data sources on the basis of the emerging theory produced by the analysis. CQR researchers on the other hand, first define their sample and “...then collect all the data using the same protocol to ensure constancy of response within a homogeneous sample of participants rather than alternating between data gathering and data analysis as in grounded theory” (Hill, et al. 1997, p. 521). The project under presentation had a clearly defined target group: four therapists from the Family Unit and families that the therapists assessed as having been helped and that had not been helped, families about whom therapists were uncertain regarding the result of therapy and that had expressed either positive or negative experiences using the SRS and ORS. The researcher wanted to know the experiences of such a pre-defined group and therefore chose to follow CQR and to not use theoretical sampling.

2. Rennie (1992) advocates the use of one researcher as a viable position. Giorgi (1985) follows this and states that “consensus among researchers is not an intrinsic demand of the method” (p. 13). CQR on the other hand, argues for the use of a team to arrive at consensus judgements and also to use auditors to check all the work. This researcher sees the advantages and disadvantages of both these positions but the aim and agenda of this project was to look into the possibilities, advantages and disadvantages of using one researcher throughout the project. In a small team with high productivity demands it is unrealistic to use more than one person at a time for research purposes. Rennie and Giorgi’s position was therefore followed.

3. One problem experienced when reviewing different qualitative methods is that the actual steps of the analysis are very often formulated unclearly. Hill et al. (1997) comments on this experience and states that “determining how to do qualitative study has been difficult because the steps are described only vaguely in the literature ...” (Hill et al. 1997, p. 518). A comparison of Rennie et al. (1988) and Hill et al. (1997) lead to the following assessment: Rennie et al. begin by dividing the interview protocols into meaning units. Then they describe a two level condensation process which for this reader was not as detailed as that of Hill et al. (1997). Haavind (2001) describes qualitative research as transformation of data through different steps or levels towards greater abstraction. Conversations are transformed into audio

recordings which are transformed to text which is again transformed into meaning units. From this point on Hill et al. (1997) describe the transformational process as one of three levels. The first is the organization or coding of text (meaning units in this project) into domains (i.e. topic areas). The next step is abstraction of core ideas (i.e. the “essence” of what the person said) in each domain. Then the data are compared systematically across cases and categories are created. The methodological nomenclature (domains, core ideas, categories) and descriptions given by Hill et al (1997) were judged to provide better guidance because the different transformational steps here are better differentiated and were therefore selected for the study.

4. In Rennie et al. (1988), lower order categories are seen as specifications and properties of higher order categories in which the analysis ends with a top level category called a core category. In the study presented here, lower order categories are seen as specifications of higher order categories but a choice was made not to formulate a top level core category. This is because therapy is seen as an intertwining of several processes; in this study, three main categories are each in turn specified by subcategories. In line with a perspective underlining the importance of tailoring treatment the main categories and subcategories in the models presented here can be mixed and intertwined in different manners and all are not required to describe good therapy.

On two central aspects of the analytical process, methodological hermeneutics (MH) and consensual qualitative research (CQR) follow each other. The first is in the use of constant comparison. Rennie (1994b) writes:

“The text of a given protocol is broken into units of analysis (meaning units) and summarized. The MU summaries (...) are compared within and between protocols in the search for communalities of meaning,... The communalities are given labels, referred to as categories. The categories are compared within and between protocols in further searches for communalities. Communalities among categories are conceptualized as higher order categories. This conceptualization gives rise to a hierarchical structure, with the categories at each level serving as the properties of the category subsuming g them” (p.429).

Although the nomenclature for the analytical steps is different between MH and CQR (see above) the process of constant comparison is given equal weight in these two methods and retained in the same manner in this study.

The second aspect is the question of saturation (Rennie et al 1988). Hill et al. again uses another name, stability of findings, and gives a more elaborate description than Rennie et al. (1988). Saturation or stability of findings is reached if “...new cases do not change the results “ (Hill et al, 1997, p. 552). Hill et al (1997) describe a process in which a number of cases are collected (12-15) and a preliminary analysis of a subset of these cases (8-12) is performed, and “...if the remaining cases do not change the results substantially, the findings can be considered to be stable” (p. 553). In the analysis of the therapist interviews the number of interviewees was fixed (no others to interview) so the question of saturation did not apply. In the family interviews a preliminary analysis was performed with 8 families. The two successive interviews did not supply new categories and saturation or stability of findings was concluded.

Rennie (1994a) states that the size of the meaning units varies and in the beginning, and describes looking for fragments of text ranging in length from a single sentence to a few lines of text. He continues:

“As the analysis proceeded I came to prefer to work with larger blocks of text – text that encompassed mini-themes in the client’s reported experience.

These blocks were usually several lines in length but sometimes covered a page or two of transcript. Naturally these larger meaning units contained comparatively more meaning than the smaller units, necessitating more categorization pr. Unit. (p. 236)

My experience in this study is similar to that of Rennie. Appendix 1, table 4 and table 5 give an overview of the number of meaning units for each therapist and family. A total of 484 meaning units constitute the total material of the analysis.

Due to the use of constant comparison during all the steps of the analysis, the number of domains in use varied but the following domains came to organise the material that was turned into core ideas. In relation to the first research question concerning the perspectives of the families and the therapist on what constituted “good therapy” the following domains were used: manner of therapeutic work, effects of therapeutic work and understanding of therapeutic work. The second question concerning the use of and experience with the SRS and ORS utilised the following:

instructions, manners of use, and evaluations. Lastly, a domain for themes not related to the research questions was established.

In line with Rennie's statement that bigger meaning units contain more meaning than smaller units, the number of core ideas increased. Appendix 1, table 6 and table 7 give an overview of numbers of core ideas connected to each therapist and each family. A total of 1201 core ideas were formulated. Using constant comparison on this set of core ideas, categories were extracted and formed. In order to keep track of each idea and keep ideas connected and grounded in the data from the interviews, each idea was formulated in a short hand version based on the idea of a "web address". Rennie et al. (1988) describe using index cards for recording the condensation of meaning units. In this study this was achieved by using Word for Windows and the index card was substituted with a sequence of concepts fashioned after the idea of a "web address". The main reason for formulating these web addresses was ease of manipulation of abbreviated versions of core ideas. Working within Word for Windows using the copy and paste function, the researcher clinician was able to try out the addresses in different clusters whereas addresses retained their specified place within the different interviews. This process allowed maintenance of the close contact between the core ideas and meaning units.

An example is given below:

MU20F1 (meaning unit 20, Family no. 1)

(I=interviewer, M=mother, F=father, S=son)

I: The one we call SRS that evaluates how we have worked together, there is a question about whether the therapist has managed to listen to you, and whether we have worked on what we should work on in the manner we had decided.

M: The measure shows this clearly. I gave signals to therapist A, I scored low, that I did not think that day had given answers that I wanted. I had not been given the opportunity to talk about what I wanted.

I: When you used the measure for this did you experience yourself as heard and did the therapist take this into consideration later, the next session for instance?

M: Yes, I think he did.

F: Yes.

M: I don't know what S means about this?

I: Did you use the measure S and were there times when you were not heard?

S: Yes, I used the scale and I was heard.

Theme:

How the therapist worked; listening, working with what one should in the manner one should, and if the scales were used to give feedback on this issue.

Domains:

Therapeutic work

Core idea: Therapeutic work/manner of working/listens to (MU20F1)

Manner of use

Core Idea (“web address”):

Measure/manners of use/feedback tool/tell the therapists (MU20F1)

Measure/manners of use/feedback tool/evaluation/was heard by the therapists (MU20F1)

Categories were created by clustering core ideas together (see below). This was done by using the method of constant comparison. As stated above, two levels were chosen to express categories. The sub categories constitute the properties defining a main category. For instance in the example above the core idea; Therapeutic work/manner of working/listens to (MU20F1) is grouped together with the following core ideas:

Therapeutic work/manners of work/listens to (MU20F1)

Therapeutic work/manners of work/they listen when I tell, they don't deny it (MU127F5)

Therapeutic work/conversation/listen to everybody without regard to age (MU176F6)

Therapeutic work/manners of work/conversation/give everybody room (MU169F6)

In the analysis these became part of the sub categories asking questions, giving time and structuring the work which again were properties of the main category; “the helpful conversation”. The common feature in these examples is “to listen” which provides room and time. Time is another common aspect found in other core ideas clustered together with the above subcategories in the analysis.

4.8. Reflections on method

Elliott et al (1999) suggest guidelines for improving the quality of qualitative research. These are divided into guidelines shared by qualitative and quantitative research and those especially pertinent to qualitative research. The study presented in this dissertation has tried to follow these guidelines. Guidelines shared by both qualitative and quantitative approaches will be attended to first (appendix 1, table 8):

1. Explicit scientific context and purpose

Descriptions of both the inspirational sources and relevant findings from the field of psychotherapy research have been presented and the research questions have been clarified. In the following the relationship between the research questions and the research field will be given a brief explication. The primary goal of both efficacy and effectiveness studies within psychotherapy has been to establish the actual outcome of psychotherapy (Lambert and Ogles, 2004). Process oriented research has had as its central agenda linking process aspects, factors and events to the actual outcome of psychotherapy (Orlinsky, Rønnestad and Willutzki, 2004). Quantitative methods, in particular randomised clinical trials, are the primary methods used in establishing these relationships. Hill (2006) points to some of the advantages of qualitative research in understanding the felt experience from the individual's perspective. It is discovery oriented, suited to examine complicated phenomena and useful to

clinicians. An important issue is that the participants can tell their story without the constraints that quantitative research can impose.

In this study the word “helpful” points to the experiences of the participants chosen for investigation. In a sense, “helpful” points to the inner and subjective experience of some of the same phenomena as the word “outcome” in quantitative research. Thus the comparison below between the findings of this study and the findings within psychotherapy research can illuminate aspects not touched upon in this study nor the research field in general. One such aspect is what is happening within the clinical sessions when feedback is used and asked for within patient focused research (Aveline, 2006). The two research questions of this study are related to each other in the sense that their answers may shed light on whether and how monitoring of process and outcome and the use of feedback are embedded in a broader description of helpful therapy and how this is related to the field of psychotherapy research. The discussion below will touch upon these relationships and connections.

2. Appropriate methods

An adequate method for answering the research questions has been chosen and presented.

3. Respect for participants

The researcher has demonstrated transparency in relation to all intentions and aspects of the research, has fully informed the participants and followed established ethical standards and proceduresⁱⁱⁱ.

4. Specification of methods

Specifying the method in this study involves making transparent which elements have been used from Methodological Hermeneutics and Consensual Qualitative Research respectively (see above).

5. Appropriate discussion

A discussion of the implication of the research data and understandings will be given below.

6. Clarity of presentation

When transforming this study into three written manuscripts, clarity of writing has been a main goal for the author through exposing the material to the scrutiny of the supervisor of the dissertation, several colleagues and a professional language consultant.

7. Contribution to knowledge

In the discussion and suggestions for future research below, arguments are given for how this study contributes to knowledge production within mental health and psychotherapy.

Next, guidelines especially pertinent to qualitative research (appendix 1, table 8) will be attended to (Elliott et al, 1999):

1. Owning one's perspective

This concerns the specification of the researcher's theoretical orientations and personal expectations, both those known in advance and those that arise during the research (Elliott, et al. 1999, p. 21). Theoretical and clinical preferences and perspectives have been made transparent in 3.2. *The Researching Clinician*. In the following some ideas concerning language are elaborated on in order to clarify the epistemological and ontological position of the researching clinician.

As a clinician working in the intellectual atmosphere of the eighties and nineties within family therapy with its focus on postmodern and poststructuralist ideas, my personal perspective on language grew out of the meeting points between clinical work and theoretical studies. Let me briefly give a description of this view of language and underline that this is a heuristic description intended to be helpful to the clinician and not to answer philosophical and theoretical questions about language. At the same time these heuristics are definitely connected to philosophical ideas that have consequences for the perspective of science inherent in this dissertation. Some of these connections will be made explicit.

The persons who enter therapy are suffering. This suffering is real, just as real as the rocks, tables, computers and persons that exist around us. Suffering speaks to existence and the real. Therefore to deny the real is to question suffering and its ground. Central to therapy is to affirm what is real. Affirmation is at least partly a verbal process. One aspect of language is to affirm the real. How does language do

this? In my view, it does this by being a pointer. Language, words, are used as tools for pointing to that which is real. Traditionally, language has been seen as representational; language mirrors the real. To me, there is a difference between mirroring the real and pointing to the real. This means that by talking about the real and realism one does not mean a mirroring or doubling of that which is pointed to. Rather, the real is pointed out, that is; affirmed. Language is a rich and heterogeneous field. The real can be pointed to in different ways. This means that the real can be brought forth in different manners. Stated differently, the real can be constructed in different ways. These two functions of language can be called *the referential* and *generative* function of language.

Language is connected to two central areas. Firstly, it is realised through the nervous system. The nervous system and the constitution of the human body make language possible. The other area concerns language as a coordinated phenomenon. Language is intrinsically social in the sense that the meaning of words is always embedded in coordinated activity between humans. The meanings of words are established within a community of language users. The meanings of words are always connected to their use. These two areas of human functioning point toward two other functions of language in addition to the affirming and generative aspects. The communal and coordinated aspects or functions of language point to language as *communication*. The embodiment of language, its embeddedness in the body and nervous system also makes language *expressive* of the states of this body and nervous system. Language then is a heterogeneous phenomenon that exists in and is made possible through four interdependent functions: reference to and construction of the real, processes of communication and through bodily expression. Therapy must work within all these functions. Through language we seek to affirm the real, bring it forth in ways that fit with or are helpful to users through communication and expression of bodily states such as feelings, thoughts, intentions, preferences, hopes and other human phenomena.

The question of epistemology in family therapy has usually been viewed as one of the distinction between realism and constructionism (Flaskas, 2002; Hoffman, 2002). The above heuristic description of four different functions realised when language is used speaks to a position on epistemology that could be called *constructionist realism*. In this study this perspective has been found to have a close

kinship with methodical hermeneutics (Rennie, 2000) and the points described above provide an explication of why this method has had a dominant place in this study.

Both within science in general and the field of family therapy one of the major challenges of how to view language has come from social constructionism (Gergen, 1994). The above heuristics are closely related to social constructionism. First, what is named a generative function connects to the idea that the real is constructed through social processes and that one cannot escape language; “Once we attempt to articulate ‘what there is’,...,we enter the world of discourse” (Gergen, 1994, p. 72). At the same time the clinical situation and experience of the researching clinician is that the word “real” is of immense importance to the participants of psychotherapy. In this project this is pointed to by both the families and therapist through the importance accorded to being believed in (See article 1). Gergen describes social constructionism as “ontologically mute” (Gergen, 1994, p. 72) and therefore as not affirming the real in an ontological sense. In the clinical situation, especially through the importance of believing the other, affirmation of what is real becomes central to the therapeutic endeavour. Affirmation of the real, meaning that which is pointed out through the words used, involves acknowledging what is talked about as something that actually does exist independent of any description, while it is accessible only through some kind of description. The heuristics above seek to express that language both points to what is real and what is real exists independent of words, and that meaning is generated or constructed in different ways dependent on the language used. Following social constructionism, this construction or meaning making is again dependent on social processes, on communal coordination, and on communication. In addition, this construction is not only connected to social processes, but also to internal psychological and biological processes. Lakoff and Johnson (1999) show how the meaning of words and the metaphors we use are directly connected to the experience of bodily processes and postures in the world. Meaning making then is not only dependent on the language we use and the social and cultural processes of which we are a part. It is also dependent upon our inner experiences, feelings, emotions and bodily states. Their expression also colours the meaning we make.

2. Situating the sample

“Authors describe the research participants and their life circumstances to aid the reader in judging the range of persons and situations to which the findings might be relevant”(Elliott et al., 1999, p.221). 3.5. *The participants* addresses this point.

3. Grounding in examples

Throughout the presentation of results examples are used to exemplify and specify the categories and understandings of them developed through the analysis.

4. Providing credibility checks

Elliott et al (1999) identify four strategies for checking the credibility of the categories developed in a study: (a) checking the understanding of the categories with the original informants or others similar to them; b) “using multiple qualitative analysts, an additional ‘auditor’ or the original analyst for a ‘verification step’ or reviewing the data for discrepancies, overstatements, or errors (c) comparing two or more varied qualitative perspectives; or (d) ...triangulation with external factors (e.g. outcome or recovery) or quantitative data” (p. 222). The primary strategies chosen in this study were (a) and (d). These were implemented in the following manner:

In relation to the therapists, strategy (a) was implemented first by presenting and discussing the categories in the traditional meeting points of the Unit. Secondly, the therapists were present when the researching clinician presented the material to other therapists external to the unit in a teaching context, and thirdly, the researcher clinician was interviewed regarding the categories in a second teaching context and the interviewed therapists functioned as a reflecting team in this interview. Through this meaningfulness of the categories that constituted the therapist perspective was confirmed.

In relation to the families, the ideal situation would have been to do a check with at least some of the interviewed families. Due to practical constraints and circumstances this was not possible. Another strategy was therefore chosen. The therapists asked families that had been through treatment on the unit if they were willing to meet the researcher clinician and together look at the meaningfulness of the categories. Two families were asked and said yes. In both these families the mother and one child were present in the interview. One of the families was a single parent family. In the other the father could not be present. The researching clinician gave

first a short lecture presenting the categories concerning both the therapeutic work of the unit and the specific use of the SRS and ORS. Both mothers reported great meaningfulness of the categories presenting the treatment of the unit. One of the mothers, after the lecture, exclaimed spontaneously that she was annoyed with the researcher because he must have talked with her therapist beforehand about what had happened in her family's treatment. The description "revealed" this cheating through its precision. The researching clinician underlined that he had not talked with her therapist about what had happened but that this was the model created through interviewing the ten families. The meaningfulness of the categories produced concerning the SRS and ORS was confirmed through such conversations.

Both families interviewed agreed on the meaningfulness but put weight on different aspects as most important. The first family underlined the importance of the transparency of the therapists about their professional knowledge and the importance of structure. The other family underlined the importance of being listened to and that the therapists took part in opposing the violation they had been subjected to by a public agency.

The second strategy (d) was implemented through both reporting findings from the field of psychotherapy research (3.0) and relating these to the findings of the study. This last part is presented below in 5.0 Discussion.

5. Coherence

The recommendation of the method employed is that categories and understandings are represented in ways that "...achieve coherence and integration while preserving nuances in the data. The overall understanding fits together to form a data-based story/narrative, 'map', framework, or underlying structure for the phenomenon or domain" (Elliott et al., 1999, p. 223). Here the researcher has tried to remain close to the nuances in the data but at the same time has been reluctant to formulate a model or theory that specifies too much about the connections between the different categories developed. The aim has been to identify descriptions through naming categories and pointing to the fact that they are interrelated; however, it has not been the aim of this project to create theories about these relationships. This has also to do with a belief held by the researching clinician that theory very easily become determinate for practice. The attitude in this study is that theory in the research context primarily should function as a source for hypothesis testing and investigation,

and in the clinical domain as a source of suggestions for actions and ways of being with clients. The effects of these ways of being together should not be clarified through theorizing but through actual investigation in the clinical domain. The SRS and ORS have been investigated in this study, and this investigation has led to suggestions for further practice.

6. Accomplishing general vs. specific research tasks

The distinction attended to here is between a general understanding of a phenomenon and the understanding of a specific case. Central to both concerns is a statement of the limitations of the research project. First of all, this study is a study of a specific case; the work of and within the Family Unit. Second, through interviews on this practice categories concerning what ten families and their therapists described as helpful therapy were generated. The family perspective points beyond the Family Unit in the sense that these families could be met in ways that reflect the content of these categories in another context; however, the family perspective described here can not necessarily be applied directly to families other than these ten. This is one main limitation of this study. The therapist perspective describes a preferred and intended practice but whether this practice is actually realized has not been investigated. The overlap between therapist and family categories suggests that the therapists follow their intended practice, but gives no evidence to support this. Questions of outcome, causation and correlation between categories are far beyond the scope of this study. In *5.0 Discussion* the developed categories will be discussed in relation to the field of psychotherapy research. The fit of the categories with the results of research in this field will be important in evaluating their usefulness in other treatment contexts.

7. Resonating with readers

The last point of Elliott et al (1999) concerns whether or not “(t)he manuscript stimulates resonance in readers/reviewers, meaning that the material is presented in such a way that readers/reviewers, taking all other guidelines into account, judge it to have represented accurately the subject matter or to have clarified or expanded their appreciation and understanding of it” (op. cit. p. 224). The researching clinician as writer seeks to fulfil these guidelines by clarifying what has been done; however, the final assessment is in the hands of the reader, just as in monitoring therapeutic

practice; the therapists are in the hands of clients and family members.

In addition to the above this researcher has had as an important concern the fact that he is part of the practice studied. Two concerns have been important here. First, how to use this insider position in a constructive manner, and second, how to increase the possibility of seeing and discovering something new and not only “rediscover” what is already known within this insider perspective. Constructive here means to balance the realist and relativist aspects of the method of analysis, to use the subjectivity of the researcher to bring out the distinctions inherent in the material and to use the knowledge and insider perspective of the researcher as a guide to discover, point out and reveal the various distinctions, aspects and categories that exist in the material. This implies a reading strategy for the interviews in which the researcher uses his insider knowledge and general knowledge to point out the possible categories existing in the material. It is the material that constrains the categories created but they are co-constructed given that it is the knowledge and position of the researcher that allows them to be discovered. This does not mean to bracket the position of the researcher but instead to use it actively as a tool for making distinctions and defining possible categories. Two aspects of the subjectivity of the researcher are particularly relevant here. First, his experience of the known, and second, his experience of the not known. The first is the use of familiarity as a reaction that reveals distinctions. The other the use of non-familiarity and the reaction of surprise as a tool for identifying the new and not-yet-thought of.

As an example, when reviewing the categories it becomes clear to this researcher that the sub category “asking questions, giving time and structuring the work” (Article 1) was evoked by statements that fell within the familiar about questions and time. At the same time “structuring the work” incorporated statements that were more connected to the unfamiliar in that these therapists, including the researcher, in accord with their inspirational sources, were reluctant to work with preplanned or manualized structures. Statements that concerned participation in the form of activities and doing things with the families fell into the domain of the familiar. At the same time, the presentation of statements of expectation for therapists to have knowledge and participate with this knowledge could be seen to break with the ideal of the inspirational sources of not taking an expert position. The feelings generated in the researcher when meeting such statements highlighted the issue of therapists’ knowledge use as an important aspect of helpful participation.

On the other hand, the sub category “nuancing the nuances” is based on part of an interview that evoked feelings of surprise and lack of understanding which in turn led to the interpretation of this event as an example of the non-pathological gaze. The sub category of generosity evoked feelings traditional in Norwegian culture articulated through “the Law of Jante: “one should not believe too much in oneself”. This reaction led to the realization and interpretation that for this Unit, generosity is a central value and part of this involves acknowledging that the evaluation of acts as generous is always done by the one these acts is directed at. Other examples of how knowledge of psychotherapy research led to sensitization towards specific statements concerns the subcategory of “giving of oneself”. When the mother in family 2 makes the following statement “They are giving much of themselves. You feel it”, this directs the researcher directly to research findings about self-disclosure (Hill & Knox, 2002) and the sub category “giving of oneself” becomes a way of connecting to these findings in this particular project.

This reading strategy can also be found as part of the actual interviews.

Consider the following:

Therapist B.: Lately I've thought about it a lot and I've wondered how we can do it because several have mentioned it as a problem. If we are to measure whether there has been a change or not, they don't remember where they placed themselves the last time, and I have said, say how you think the last week has been and if it feels a bit better, or a bit worse and then mark that without thinking about whether you remember the last score or not. But I see that at least some don't find it that easy.

Interviewer: No.

Therapist B: Some sit for a very long time with it.

Interviewer: What I do believe we must look at is the aspect of measuring and I'm used to the fact that when you are to measure something like this you will never be fully finished.

Therapist B: But you're sitting there with the ruler and measuring, aren't you?

Interviewer: Yes, I do that when they have finished marking the scales, but I'm saying that I think I downgrade the measuring aspect of it, and it has more to do with me being given an opportunity to ask the question, “ what does this mean?”.

When the interviewee raises a question around the difficulties experienced when family members become caught up in questions of “correct” measurement, the interviewer certainly can be seen here to leave the role of interviewer and to become an adviser giving guidance about downgrading the measuring aspect and upgrading the opportunity for asking questions. In the interviews, especially in the interviews with the therapists, there are sequences in which the interviewer can be seen to leave the role of interviewer and instead become a participant with opinions and views like the persons he is interviewing. In this way, embedded within the interview there exists another interview in which the interviewer responds to his own questions or the answers of the interviewees. I have called this metaphorically “the N+1- interview”. There are four interviews with the therapists. Embedded in this is a “4+1=5”; a fifth interview, revealing aspects of the ideas, perspectives and preferences of the interviewer. The example above shows how the interviewer, in a clinical situation in which the family members are caught up in questions of correct measurement, might downplay this concern and instead use the family’s response as an opportunity for questions. This again reveals that this interviewer is especially responsive to answers identifying the SRS and ORS as opportunities for question asking. In addition, the responses of the interviewer can again be used as invitations for the interviewee to comment upon which can again illicit the hidden or implicit knowledge of the interviewee.

“The N+1-interview” is a strategy applied in order to keep in contact with and acknowledge how ideas, perspectives and preferences of the interviewer/researching clinician are definitely an aspect of the categories. This does not mean that their place in the study is determined solely by the researching clinician but that when they are revealed in the material they are more easily picked up by this researching clinician. The presuppositions of the interviewer contribute to creation of something distinct, both through the interview and the analysis, while other aspects and experiences are marginalized. The best test of whether the interview has managed to convey the informants’ thinking and practices is that they recognize themselves in the product.

4.9. Ethical considerations

Following Kvale (1996), qualitative research on human beings imposes three ethical demands on the researcher; informed consent, confidentiality, and responsibility for consequences of the research. Informed consent was grounded in this study both in written and oral information and responding to questions from the informants throughout the whole study. Confidentiality has been maintained. Private and other identification information applying to the families has been omitted from the study. Concerning the therapists, the specific context and size of the Family Unit can in some instances make it possible for people who are familiar with the unit to identify individual therapists. The rule was therefore that any information that assessed as posing possible ethical or personal dilemmas for the interviewee was omitted from the study. This is also related to Kvale's third demand of responsibility for consequences. Any response or statement from the interviewee that could be assessed as harmful for this person or others was omitted. This is related to the specific context of this study. The position of the researcher is, as stated above, an insider position. In relation to the therapists this meant he was a colleague of the interviewees. In relation to the families, "insider" meant the researcher was inside the practice studied while outside the position of the family. Concerning the therapist-researcher relation, this meant a dual role as researcher and colleague for the researcher with possible ethical and collegial consequences for both parties involved. In this study, the researcher has attempted to deal with this through monitoring effects of the research process in the existing professional meeting points of the Family Unit and relationship have been attended to by the researcher through the use of monitoring questions for his colleagues/interviewees. In relation to the families, it was decided that the therapist should not interview families he was currently working or had worked with. In one family, the researcher had participated in some meetings but had not had treatment responsibility. This was discussed with the family who stated that this was not hindering them in participating in the study. In addition, for all the families but particularly this family, it was underlined that the interview could be terminated at any point and its results would be disqualified and taken out of the study on their request.

4.10. Concluding remarks concerning method

Kvale (1996) formulates the concept of validity within a postmodern frame. He distinguishes three approaches to validity: validity as quality of craftsmanship, communicative validity and pragmatic validity. The above explication of criteria by Elliott et al (1999) seeks to implement Kvale's first approach. By applying a qualitative method that underlines rigor, grounding the analysis in data and the use of reflexivity (Rennie, 2000, 1995), and seeking to realize these processes to one's best ability, the ideals of validity as quality of craftsmanship have been sought to be met.

Communicative validity "...involves testing the validity of knowledge claims in a dialogue" (Kvale, 1996, p. 244). This has been attempted through the different credibility checks described above. In addition, the discussion (below) can be read as a dialogue between the research findings from the general field of psychotherapy and the findings of this specific project. In this discussion both points of similarity and points of difference between these two foci are discussed. In addition this researcher has presented the findings at a series of conferences and teaching contexts, receiving responses that speak to the meaningfulness of the categories of the project.

Pragmatic validity deals with "whatever assists us to take actions that produce the desired results" (Kvale 1996, p. 248). For most of the period of this project, the researcher has been working in the Family Unit participating in the practice described in the project. This has had the consequence that parts of the researching clinician's practice have been given support, such as always keeping heightened attention on the "helpful relationship". Aspects that previously were not given as much attention, such as the use of technical and psychological expertise, have gained increased attention and there is heightened awareness of the importance of violations caused by social welfare and health care systems, of the experience of client vulnerability and of how therapists can be potential pathological influences. In addition, reports from colleagues underline the pragmatic utility of these categories.

Reliability concerns how consistent the results are (Kvale, 1996). One aspect of this is the issue of leading questions. Stated differently, "Can the interview results not be due to leading questions?" (Kvale, 1996, p. 157). Although documenting and accepting that the wording of a question can shape the content of an answer, Kvale continues: "...it is often overlooked that leading questions are also necessary parts of many questioning procedures; their use depends on topic and purpose of the investigation" (Kvale, 1996, p. 158). In this study, the metaphor of the "N+ 1"

interview tries to catch the fact that the interviewer is using his inside knowledge to bring out hidden or unexplicated knowledge on the part of the interviewee. In addition to this, the interview has followed Kvale's (1996) description of employing leading questions to check the reliability of the interviewee's answers and to verify interpretations and understandings of the interviewer.

5.0. Results

5.1. Summary of article 1

Collaboration: Family and therapist perspectives of helpful therapy

The aim of the article is to examine how four therapists and ten families from a family therapy unit in Norwegian Child and Adolescent Mental Health describe helpful therapy. In addition, the article concerns the differences and similarities between the perspectives of the families and therapists, and what happens to guiding ideas from postmodern language oriented family therapy in this context?

A qualitative interview study was carried out with four therapists and ten families. Data was analysed using a modification of grounded theory. Theoretical sampling was not employed as the target group was pre-defined. Saturation did not apply to the therapist interviews, and was reached after ten families were interviewed. A participant check was done in order to secure the different voices and the variety of perspectives in the material.

Two sets of categories, one for therapists and one for the families, each specified by sub categories, was generated and constitutes the therapist and family perspectives of helpful therapy. By attending to the similarities between the two sets, three concepts have been defined. These are; conversation, participation and relationship. Support for these findings is found in psychotherapy research. Both perspectives point towards expansion of the original guiding sources of the unit. It is suggested that this is connected to the particular focus on behavioural problems in the context of the unit. It is concluded that the language oriented models must be expanded to include action oriented forms of therapeutic practice and that the professional knowledge and skills of therapists do not stand in opposition to the non-expert and not-knowing position of these models when therapy is seen and implemented as a collaborative venture between families and their therapists. The imperatives here for therapists concerning both research and training are to generate and access as many skills and knowledges as possible and to do this within the areas highlighted by the concepts of conversation, participation and relationship.

5.2. Summary of article 2

Collaboration: Working with process and outcome

The aim of this article is to explicate how families and their therapists evaluate and describe the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work. The practice studied was a local practice of a family therapy unit in Child and Adolescent Mental Health and was guided by the work of the Therapeutic Institute for the Study of Therapeutic Change, patient-focused research and ideas from postmodern language oriented family therapy. The central research questions were: What are the important ingredients that families and their therapists identify when monitoring process and outcome in a therapeutic practice?, How is this practice evaluated?, and How is it related to the inspirational sources of this unit?

A qualitative interview study was carried out with four therapists and ten families. Data was analysed using a modification of grounded theory. Theoretical sampling was not used as the target group was pre-defined. Saturation did not apply to the therapist interviews and was reached after ten interviewed families. A participant check was performed in order to secure the different voices and the variety of perspectives in the material.

Categories were generated both for the questions of evaluation and of how these measures were used. Both perspectives concluded that these measures are feasible and should be used but that there are possible disturbances and difficulties that should be attended to. In the analysis of the therapist data, six conversational types were identified, and in the analysis of the family data four conversational processes were identified. The evaluation measures were regarded as tools with therapeutic functions as conversational aids. This is in addition to their intended function as tools for monitoring process and outcome and supplying feedback to therapists. Working with process and outcome in this manner means to establish and strengthen collaboration between service users and therapists. It is concluded that the findings of this study support the centrality of collaboration and the role of the measures in expanding and securing such collaboration. Further, through monitoring practice, research based therapy and post modern language oriented forms of therapy are brought into a productive contact.

5.3. Summary of article 3

Therapeutic collaboration and formalized feedback: Using perspectives from Vygotsky and Bakhtin to shed light on practices in a family therapy unit.

The aim is to reflect upon the findings of our study through concepts and perspectives from the work of Vygotsky and Bakhtin. The family therapies that have inspired the practices reported on are sceptical towards the technical aspects of therapy, fearing objectification of the service users. The aim here is to show that the use of tools can be an opening for collaboration between families and their therapists.

Vygotsky's concept of mediation concerns reaching a goal through indirect means. The study reported on uses standardized measures as tools to supply feedback on process and outcome and for setting up conversation types and processes. These mediate new actions and understanding and become important aspects of therapy as a collaborative venture. For Vygotsky, tools are used in interaction with the social environment in a cultural and historical situation. The interaction is internalized and becomes mental phenomena. Bakhtin's concepts of dialogicality supplement this perspective. In dialogicality, when a person speaks an utterance, at least two voices are present simultaneously, the voice of the one speaking, and the voice of the one being addressed. The voice of the other is implied in the original spoken voice. This underlines the idea that there are multiple ways of representing reality leading to an acceptance of heterogeneity in how reality can be described and that privileging one voice over another is an act of power.

The work of the Family unit rests partially on the idea of reality as heterogeneously described and the reluctance to privilege descriptions outside preferences of the service users. Therapists and families create new options and possibilities through collaborative actions. A special event is when there is a situation of no-change and lack of development. The concepts of the zone of proximal development and the metaphor of scaffolding illustrate how a collaborative situation can be set up to create new developments for both families and therapists. It is concluded that therapeutic practice must be monitored in each single case and that feedback can be implemented within a practice guided by post-modern, language oriented family therapies. Further, it is concluded that it is the responsibility of therapists to have access to methods and techniques that can function as such tools.

6.0. Discussion

In the following discussion, five areas will be touched upon. First, the findings of this study will be compared with those discussed in the review of the field of psychotherapy research. Second, the use of the SRS and ORS and the practices associated with these measures will be attended to. Third, the clinical practice that the findings and comparisons speak to will be specified. Fourth, this discussion will converge on the question of what is psychotherapy, with a suggested definition that fits the findings of the study. Lastly, areas for future research will be pointed out.

6.1. Comparing the findings of this study to others in the field of psychotherapy

The APA (2006) suggests that the individual therapist, the patient, the therapeutic relationship, the question of theory specific ingredients versus common factors, and the monitoring of outcome as central research topics of psychotherapy research. The presentation above attends in addition to the same issues in relation to children, adolescents and families. The results of the study presented in this dissertation are communicated as categories representing the perspective of the families and the perspective of their therapists. Article 1 extracts three concepts: conversation, participation and relationship, expressing the overarching similarities between these descriptions. These and the specific ingredients of the two perspectives will be used in the following comparison.

Psychotherapy research (Lambert, 2004) confirms the importance of the therapeutic relationship, especially the therapeutic alliance, with a heightened attention to collaboration between service users and therapists (Horwath and Bedi, 2002). “The helpful relationship” parallels these findings, and in both perspectives the emotional bond is connected to a suggested inseparable trinity; listening, taking seriously and believing the client. The sub category “generating collaboration” includes, in addition to the alliance, proper conduct in which sincerity combined with lack of prejudice towards the family are of utmost importance. This means to behave towards the family as an ordinary person and the refusal to establish oneself in a top down position. This is in line with the recommendations of Burns et al (1999) for how therapists should relate to the parents of their clients. In the therapist perspective, this is expressed within the main category “to be where people are”. Here “generosity” supplements “the helpful relationship” in expressing the

importance of always valuing, including and accepting that which the service users present.

Both these perspectives receive confirmation from the research on self-disclosure, which is seen as a promising element of the therapeutic relationship (Hill & Knox, 2002). “Giving of oneself” and “blurring the differences” point to the importance of the therapist making him or herself visible as a person, and that events and stories from personal life are used in shedding light on the life of the family members.

The work of division 29 of the American Psychological Association (Norcross, 2002a) states the importance of tailoring treatment to the individual client. Within the presented study, tailoring implies fitting therapy to the whole family. “To be where people are”, “being flexible” and “having many possibilities” all point to the necessity and importance of tailoring treatment to the needs and potentials of the family. This goes beyond fitting a specific method to the client and towards fitting the whole therapeutic context to the family; that is, where, with whom, when, how and in what quantity therapeutic ingredients must be fitted to the family. Psychotherapy research concludes that both therapist and patient characteristics have impact on outcome (Beutler et al., 2004; Clarkin and Levy, 2004). The results of our study highlight two important features of this conclusion. First of all, that these characteristics must be matched, that is; the therapy must be tailored to the patient characteristics and preferences. Second, this tailoring is the responsibility of the therapist. In article 2 this is underlined through the necessity of taking feedback seriously and especially when alliance ruptures or detrimental development is identified. Baldwin et al (2007) also state that these therapeutic issues actualize therapist change.

In “the helpful relationship” one aspect appears to be particularly strong in our study. This is the fact that the helping system and its labourers are potentially toxic factors for some families through behaviour that violates the families and creates disparagement and degradation. That therapy can have detrimental effects is well documented within patient- focused research (Lambert, 2007) and there are reports on the importance of client advocacy within qualitative research (Gehart & Lucas, 2007). These reports give clear support for the importance of the sub category of “fighting violation, disparagement and degradation”. It seems safe to conclude that there exists

good support within psychotherapy research for “the helpful relationship” and the related therapist category “to be where people are”.

One of the big questions within psychotherapy research is how much it matters what therapists do and what part techniques and manners of working play in the outcome of psychotherapy (Ogles, Anderson, and Lunnen, 1999; Lambert and Ogles, 2004). As stated in the above review, theory driven methods are deemed efficacious, but it is an open question whether or not this points to specific factors or common factors. Psychotherapy has traditionally been “the talking cure”. The generated perspectives of this study focus on “the helpful conversation” and “the lingering conversation and the big tool box”. The use of questions combined with allowing enough time to linger on questions and answers is central for both families and therapists. Cooper (2008), reviewing the research on questions, cites Williams (2002) in concluding that open questions are rated as moderately helpful while closed questions are given a low helpfulness rating. It is also concluded that questions can be challenging in that they can be opportunities for deepening of experiences, but that it is important not to use questions too much. In the results from this study, questions and the opportunity to linger on what the question elicits are underlined as very important, but it is made clear that sooner or later this lingering must lead to specific manners of structuring the work. For the families the questions must lead somewhere and they must be asked within “the helpful relationship”. For the therapists “the lingering conversation” also must lead somewhere in the sense of specifying and helping the therapist choose ways of working from their “big tool box”.

Talking in therapy thus is both an open ended lingering process and a targeting and structuring process. “Giving and receiving feedback” are important for the families, especially receiving feedback. One of the recommendations from some of the families in this study is that the Family Unit can work more on giving negative feedback to the families. They want help in identifying what could or should be changed. When receiving feedback it is of the utmost importance that therapists take this process seriously and change according to the feedback. This result reflects and is given strong support in patient-focused research. The evaluation of the SRS and ORS by both families and therapists confirms this.

The families also underline the importance of “reformulation”. This concerns both reformulation of specific events and perspectives, but can also be interpreted as an underlining of the importance of creating new meaning. If defined as a form of

interpretation, reformulation is supported by research when connected to relational matters on condition that one avoids high levels of transference interpretations. Within brief therapies “interpretations should primarily focus on the central interpersonal themes for each patient, namely, the quality or accuracy of such interpretations” (Crits-Cristoph & Gibbons, 2002, p. 298). Cooper, again referring to Williams (2002), shows how the use of interpretations, broadly understood as processes of discovering new connections, perspectives and understandings has compelling evidence to support it. This is what the families underline within the sub category of “reformulation”. Seen together with the therapist perspective that underlines the lingering conversation and the use of questions, the above is seen as supportive of conversation as an overarching concept.

Connolly Gibbons, Crits-Cristoph, Barber and Shamberger (2007) conclude that the quality or accuracy of interpretations might be more important than frequency of interpretations. Consistency with the formulations of the patient is an important part of quality. In the findings of our study, high quality interpretations are defined as fitting with the perspectives and theory of change of the service users. An important question becomes what helps the therapists in making adequate interpretations or reformulations? In our study the “the helpful participation” and “to get a taste of it” point to possible answers to this. The therapist perspective, underlining “sharing experiences”, “participating”, attaining mutual definitions” and “blurring the differences”, can be seen to point to the fact that understanding the family is grounded in the therapists having similar experiences as those of the families. This is achieved by actively participating in the life of the families. It means to participate in problem solving trials, in doing oneself what one recommends the family do, and through this being allowed to experience successes, impasses and failures. It is from this platform of understanding grounded in similar experiences that new manners of understanding and acting can originate and be investigated. Reformulations as new manners of understanding joint experiences can thus be presented as supplementing the original understanding from the perspective of an insider. The reformulation is grounded in the acknowledgement from both parties of a similar experience.

Empathy is a concept that traditionally has pointed to the therapists’ experience of the other and it is empirically well established as related to outcome (Bohart, Elliott, Greenberg, and Watson, 2002). The above points towards empathy but can be interpreted to go beyond empathy towards descriptions based on

developmental concepts (Stern, 1985, 2004, 2008). Daniel Stern (2004) has described and suggested the clinical relevance of the present moment. He relates this to the concept of implicit relational knowing and to the fact that nonspecific factors have a central place within psychotherapy research (Stern, 2008). This triad of the present moment; what happens here and now, implicit relational knowing; "...representations of how to proceed, to do things..." (Boston Change Process Study Group, 2008, p. 128), and the above documented non specific therapy factors points to the overarching concept of participation of this dissertation.

The concept of participation with its weight on sharing experiences, getting a taste and blurring the boundaries between service users and therapists can be seen to point to the present moment and, for the therapists, to give themselves over to what happens in these moments. This means to give oneself over to one's implicit relational knowledge and, as such, the concept of participation means an increased attention to the personal involvement of the therapist in therapeutic activities. This dissertation concludes that it is by immersing themselves in the life of the families through personal participation, involvement and giving of oneself that therapists can increase the possibility of putting these mutual experiences into words in the form of high quality reformulations by having such first hand experience of the life contingencies of the family.

Seen from the family perspective the concept of participation involves more than this sharing of experiences. It means not only a personal, experiential involvement but also oneself with all of one's professional knowledge and authority. This means using skills and techniques, to be transparent about one's rationale and perspectives that are relevant for the family. The therapists participate with their entire knowledge base, both in actual action and making strategies available for families to use. It also means to participate with reports and specialist declarations where these are needed in order to help the family. The expectation of the families is that the therapists have skills and knowledges that they apply in collaborative efforts together with the family. This means that although the research is ambiguous on the role of techniques and methods, these families confirm their importance within the collaborative relationship between families and their therapists. The question of specific vs. common factors then is not one of either- or. One possible conclusion from this, also following Stern (2008), is that techniques and models are avenues and opportunities to establish a helpful relationship. Cooper (2008) is clear that it is an

unsettled question within the field of psychotherapy research whether techniques lead to a good therapeutic relationship or if the therapeutic relationship is a fundament for techniques to work. By using her or his technical skills and theoretical and research based knowledge with the families in a collaborative manner, a relationship is created that implies new relational learning for the family which again can give rise to new verbal formulations and understandings.

6.2. Use of the SRS & ORS

The importance of feedback is underlined in both the family and the therapist perspective. The families state this explicitly while the therapists communicate it through the choice of using the SRS and ORS. Although the families are most concerned about getting feedback from the therapists, they confirm both the feasibility and importance of the use of these measures and especially the importance of the therapists taking seriously and follow the feedback. Both perspectives support the conclusions of patient focused research and the clinical specification given by the Institute for the Study of Therapeutic Change (Lambert, 2007; Miller, Duncan, & Hubble, 2004).

Articles 1 and 2 in this study can be seen as a specification of a therapeutic practice in which monitoring process and outcome and the use of feedback is embedded. The practice used in this unit differs from the classical experimental situation of patient focused research in that both service users and their therapists continually are exposed to the feedback and it is continuously implemented within the therapeutic practice. The SRS and ORS are used as conversational tools and are a central part of the therapeutic practice. A central difference in relation to patient focused research is that both on-track and not-on-track cases are exposed to conversations around process and outcome. The results points to the fact that the use of the SRS and ORS goes beyond the simple use of feedback. The family perspective identifies three conversational processes in addition to obtaining feedback. Focusing, structuring and exploring are suggested as important conversational processes that are facilitated by the use of the SRS and ORS. The therapist perspective supports this finding by specifying types of conversations that are also facilitated. Further research is needed on such processes and types of conversations. This points to the possibility that the use of such measures not only decreases the development of being not-on-track, but may serve other functions as well. For instance, results reported by Anker,

Duncan and Sparks (in press) point to the possibility that using these measures in this specific manner prevents not-on-track developments from occurring within on-track cases.

Lastly, the use of the SRS and ORS is supportive of ideas about following the preferences of clients, and therapists managing to change in order to re-establish collaborative relationships when confronted with impasses and detrimental development. It is essential to identify such developments and for this the SRS and ORS are invaluable. Reviews of research (Duncan & Miller, 2000a) point to the fact that therapists are in danger of doing poor evaluations of the therapeutic relationship and alliance. A supplementary perspective provided by the service users through the use of standardized measures reduces the danger of missing out on such situations.

6.3. What kind of therapeutic practice do these findings speak to?

Denzin and Lincoln (2005) introduce the concept of *bricolage* and the *bricoleur*. These metaphors speak to the epistemological position of this project. They write: “The researcher may,..., be seen as a *bricoleur*, as a maker of quilts, or, as in filmmaking, a person who assembles images into montage” (Denzin and Lincoln 2005, p. 4). This points to processes of mixing things together, blending, taking odds and ends and bringing about “..a pieced-together set of representations that is fitted to the specifics of a complex situation” (Denzin and Lincoln 2005, p. 4). With reference to filmmaking they introduce *montage*. This process creates “..the sense that images, sounds, and understandings are blending together, overlapping, forming a composite, a new creation.” (Denzin and Lincoln, 2005, p. 4). The result of this is an emotional, gestalt effect (Denzin and Lincoln 2005).

Through the analysis of the interviews in this project, the metaphors of bricolage and montage can be seen as leading images. Central to the epistemological suppositions here is that this montage points towards something outside itself. As such it could be called a representation, but within the epistemology of this study it is considered constructionist realism. At the same time the concept of bricolage in this study can be seen to point beyond an epistemological position to describe an important aspect of the findings of the study. This concerns the fact that the relationship between the overarching concepts and the categories and sub categories they build upon seems to conform to a form of intertwining and braiding as seen in a

bricolage. The reviewed research points also to such a braiding of aspects, attributes and processes.

The review of psychotherapy research (3.1) gave ambiguous answers to the question of whether therapists affect the outcome of psychotherapy (Elkin et al., 2006; Kim et al., 2006). Beutler et al (2004) concludes that the effect of therapists' traits must be investigated in relation to aspects of patient functioning. The key phrase is patient-therapist compatibility. We know that some therapists matter but some matter more than others (Lambert & Barley, 2002; Miller, Hubble & Duncan, 2007) but the question is how this comes about. The interplay and braiding of different aspects of different factors involving the therapist and the patient is indicated as important. The same goes for the relationship between patient and method. Again, the match between them is crucial (Beutler, et al., 2004). Evidence also points to the fact that therapist attributes such as flexibility, honesty and others influence the therapeutic alliance (Ackerman and Hilsenroth, 2003), and that repair of alliance ruptures through the therapist acknowledging and pointing out his or her contribution to and part in the rupture event is correlated with outcome. Shifting the focus to patient characteristics and client variables, the same question arises in the form of which client and therapist characteristics interact most saliently to produce outcome. Concepts such as severity of symptoms and functional impairment are related to outcome as well as social and cognitive dysfunction, expectation of improvement, endogenous depression, duration of the current and personality disorders (Clarkin and Levy, 2004).

Again a recurring theme is the match between patient and therapist. Persons suffering from personality disorder have problems with personal relationships. To match such interpersonal problems, friendliness, flexibility and responding in ways that reduces behaviours that could be classified as "resistance" is of the utmost importance (Beutler et al, 2002). The central theme of collaboration in this dissertation underlines this. Horvath and Bedi (2002) argue for collaboration and consensus as the most important and distinguishing features of the therapeutic alliance (Bordin, 1979). Tryon and Winograd (2002) document the same together with the importance of the mutual involvement of patient and therapist in a helping relationship. Baldwin et al (2007) conclude that the therapist must have interpersonal skills that can facilitate the establishment of shared decision making with frequent discussions of goals. Again we meet the fact that when clients do not match the

collaborative invitations of the therapists, a clinical problem arises that is best solved by looking at the therapist rather than exclusively patient characteristics. This leads directly to situations in which the therapist should look for help and support in solving his or her clinical problem. The solution chosen by the more traditionally oriented evidence-based practices is to increase the search for knowledge through intensifying assessment and diagnostics and identifying the best available research (Norcross et al. 2008). This dissertation does not disqualify or stand in opposition to the importance of assessment, diagnostics and best available research, but it raises questions on their place in the singular case; how is the knowledge generated to be used? It is the assertion of our study that the use of assessments, the stated diagnosis and the best knowledge available must be subordinated to the actual responses of clients and families. This places continuous monitoring of the actual course of therapy at the centre of therapy. Psychotherapy research results (Castonguay & Beutler 2006; Goodheart, Kazdin, & Sternberg, 2006; Norcross, 2002a), and those of our study point towards the importance of flexibility and the ability to move and change in accordance with the responses of the other. The description of the work of the Family Unit exemplifies a specification of what a practice inspired by a bricolage can look like and it is not primarily constrained by theoretical or generalised knowledge, but by the actual responses and feedback from those most concerned with this work, the patients and their families. This perspective founds therapy on the family. The client's theory of change (Duncan and Miller, 2000b), with the use of the SRS and ORS, is an invaluable conceptual tool for the therapists in this work. To follow and to found therapy on the family means to construct the form and content of therapy from the ideas, preferences, aims, and principles of the family. It is to take seriously the concept of the theory of change of the family and let this direct the form and content of therapy. It does not mean that the therapist is a passive non-participant in the building of this therapy. Rather, the therapist becomes an active consultant and contributor to the construction and development of a therapy tailored to the family (Norcross, 2002a, 2002b). Central to this contribution is the knowledge base that any therapist represents. This knowledge is a central ingredient of helpful therapy together with the knowledge of the family. In addition, a need for learning arises when the preferences of the family do not match the knowledge base of the therapist. This leads to a constant knowledge-seeking process within the unit.

This way of working has a fundamental effect on how to think about lack of progress and development towards the preferred state and situation of the service user. Traditionally, lack of change has given rise to conceptualizations primarily connected to the client and family members. Concepts such as resistance, lack of motivation, and treatment incompatibility all point towards the client and the service user (Beutler et al., 2002). Confronted with a situation characterized by lack of change, therapists have applied these concepts to clients and their families. Within the perspective of this study, lack of change points towards the therapist and his or her way of working. Stated differently, resistance is not an aspect or characteristic of the client and his or her family. It is an aspect of the method used, and as such, lack of change points towards change in the therapist and his or her way of working.

This therapeutic work is governed by the idea that the family and the therapist use what they need or prefer in order to reach their goals, solve the problems, or live their dilemmas (Sundet, 2004d). This means that all knowledge and every skill—whether research-based, theory-based, or based in the participant’s personal and professional experiences—will be used. As such, the material or practice described in this dissertation does not represent a therapeutic model or method. It is based on all available knowledge, and could be called a perspective or a position. Viewed in this manner, the position adhered to in this study is an eclectic position, and it can be named *a radical eclectic* position. The word eclectic is etymologically connected to *gather, to assemble, to choose, to pick out*. The dictionary definition is “borrowing freely from various sources” (Hornby, Gatenby, & Wakefield, 1963). It points to the importance of being free to choose, mix, and blend all possible elements from the knowledge bases of the participants. Etymologically, two meanings of radical are also of special interest here; first, to grow out from, to form branches, to branch out, to create a network or rhizome (Deleuze & Guattari, 1988; Partridge 1966). Branching could also imply an end point of the branch, an extremity or margin. Second, the meaning is that of pertaining to roots, having roots, or being deeply rooted. Semantically there is a root-branch alternation here (Partridge, 1963) that implies that to be radical could be seen as both being rooted in something and as branching out from this, forming a network. To be eclectic is to pick and choose without these choices being dictated or constrained by demands for logical or theoretical coherence. Here there is high tolerance for fragmentation and parts, and upholding a reciprocal agreement or understanding within a coherent system is not

decisive for the choices. What, then, is decisive for the choice of a radical eclectic position? A radical eclectic position lets the choice of method, action, statement, or question be rooted in, and branching out from the service user. As stated above it involves subordinating theoretical and research-based knowledge and clinical experience to the perspectives of and feedback from the service users.

Cooper draws the conclusion that “at the heart of most successful therapies, is a client who is willing and able to become involved in making changes to her or his life” (Cooper, 2008, p. 157). Client willingness and ability to use what the therapist provides become the key predictors and factors in this perspective. Unfortunately, this can be seen as a punctuation making the client the primary cause of both change and no-change. The above conclusions about therapeutic practice raise questions about this punctuation. Change is a collaborative venture where both therapist and client matter, but in situations of no-change, following Baldwin et al (2007), the primary responsibility for change is with the therapist. No-change does not testify to lack of willingness and ability, only that what is brought forth does not fit. This makes situations of no change a context for discovery; a place for creating or generating a process of exploration that can lead to the discovery of tasks, perspectives and actions fitting the client’s specific willingness and abilities. The danger of concluding lack of willingness and ability on the part of clients is that this process of exploration is not started and that instead a process of exclusion is instigated with the potential result that the client is judged not fit for treatment. The conclusions of this study are that when a process of exploration concerning what is effective therapy for this client is set in motion, the “unwilling” becomes willing, and “lack of ability” is discovered to be different abilities. This process of exploration includes both the professional knowledge base of the therapists and the knowledge base of the client through his or her history of change and life perspectives. Searching within these different knowledge bases and experimenting with what is found, eventually may lead the therapist to new options and change. Article 3 employs the concept of the zone of proximal development and the metaphor of scaffolding as ways of explicating how both families and therapists are in need of such processes of discovery and that this is a central part of the professionalism of the therapists. Therefore the weight is on therapist, and not following Cooper, who, truth be said, expressed the equivocal state of both the research and clinical situation through the old joke:

'How many therapists does it take to change a lightbulb?' 'One, but the lightbulb has really got to want to change' (Cooper, 2008, p.157). It can hardly be called therapeutic craftsmanship to need a willing lightbulb to see the light.

6.4. What is psychotherapy?

The above acknowledges that there always is a possible tension between the therapist's perspective and the family perspective on what one should do. It is the conclusion of this study and the review of the research that therapy must be seen as a joint and collaborative venture where contributions of both families and therapists are needed. The inspirational sources (Andersen, 1991; Anderson & Goolishian, 1988; White, 2007) of the Family Unit all underline collaboration, privileging the client voice and the importance of conversations and dialogue. The above discussion and the research review confirms the importance of collaboration and relationship aspects as strong emotional bonds developed through listening to and taking seriously the service user, establishing goal and task consensus, accessing the client's voice through feedback procedures and creating new meaning through reformulations. At the same time, these sources must be expanded to include action oriented practices, active use of professional knowledge and authority and seeking to create and uphold an adequate structure of the therapeutic work. This means that in our study the interviewed families invite a stronger participation of the therapists both concerning their personal participation and the use of their professional knowledge. This again connects to the fact that although there is no clear cut evidence for strong relations between techniques and outcome, the research review points to the importance of braiding together both personal attributes and professional skills of the therapists with attributes of the service users within a collaborative relationship. In this perspective, therapeutic outcome becomes a result of interactions and intertwining of several processes and attributes of the participants and their ways of working and being. Further, such outcomes must be seen as individualized results of creating manners of working tailored to and fitting with the single service user and family. Implemented therapy must ultimately be created with the individual client and family. This speaks to what psychotherapy is. With reference to Hubble, Duncan & Miller (1999a), Grenness (2000) suggests the following definition of psychotherapy.

“(P)sychotherapy constitutes an idiosyncratic, process-determined synthesis of ideas of the client and therapist that culminates in a new local theory with

explanative and predictive validity for the specific client's situation. Therapy constitutes a co-evolution between client and therapist towards an emergent reality consisting of the following main factors; 1) to create space for the client's use of his or her own *resources* (...), 2) to secure the client's positive experience of the *alliance* with the therapist and 3) to strengthen the client's frame of reference or *theory of change* " (Grenness, 2000, p. 42, my translation).

This study conforms to this definition. In addition to underlining client resources, the alliance and the theory of change of the client, it brings forth therapy as a process of co-evolution and collaboration and it confirms it as a process through which the responsibility of the therapists is to make space for, secure and strengthen both the family and the relationship with them. In the end this must be decided by and together with the service users. Research and evidence based knowledge together with knowledge based on clinical experience must be put to use for and subsumed under such an individualized and singular practice.

6.5. Future research

This study has pointed to a need for more understanding of the participatory aspects of therapy, especially concerning experiential sharing. Further, the role of questions and ways of talking together need to be investigated more. Thirdly, the possibility of therapists being toxic through violation and disparagement needs to be investigated. One aspect of this is that the sub category "nuancing the nuances" from the therapist perspective invites a nonpathological view of families. This points to a need to further investigate whether the thinking of the therapists, especially the use of a pathological gaze on the family; that is, the family as cause of suffering, has a possible role in detrimental development in therapy. Lastly, three overarching concepts; conversation, participation and relationship have been suggested as important aspects of psychotherapy and their importance for the single service user and family lies in how they are intertwined and braided. This then identifies intertwining and braiding as a target for research. This is seen as especially resonant with the research findings concerning the concept of tailoring therapy (Norcross, 2002).

The main focus of our study has been on what the therapist can do in order to be experienced as helpful. In terms of the above perspective on psychotherapy as co-

evolution, the intertwining of different therapeutic processes and collaboration between the participants there is a need for the Family Unit to shift focus from the therapist towards the client and his or her family members. What is it that families do that is helpful for them? How do they use what therapists bring to therapy? What is the part played by the client and the family in the co-evolutionary process called psychotherapy? In the field of psychotherapy this has been investigated by Bohart and Tallman (1999). Still, in order to fulfil the project of the Family Unit in explicating all the parts of a helpful therapy the natural continuation will be to go back and interview both families and therapists on these questions. Hopefully, such a local project, when viewed in relation to the field of psychotherapy research, can make further contributions to the field of psychotherapy.

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Appendix 1: Tables

Table 1 Therapists

Therapist	Gender	Age	Experience	Profession
Therapist A	Male	49	20 years	Clinical psychologist
Therapist B	Female	63	27 years	Clinical pedagogue
Therapist C	Male	56	29 years	Social worker
Therapist D	Female	47	Second year diploma student	Student therapist
Researcher/author	Male	54	25 years	Clinical psychologist

Table 2 Families

Families	Family size	Mother	Father	Children	Interviewed	Status	Therapists
Family 1	3	1	1	1	All	Active	A & B
Family 2	3	1		2	Mother, 1 child	Active	C & D
Family 3	5	1	1	3	All	Terminated	B & D
Family 4	3	1		2	All	Active	A & B
Family 5	2	1		1	Mother	Active	A & B
Family 6	2	1		1	All	Terminated	A & X ^{iv}
Family 7	4	1	1	2	Mother, father	Terminated	A & B
Family 8	3	1	1	1	Mother	Terminated	A & B
Family 9	4	1	1	2	Mother, father, 1 child	Terminated	C & D
Family 10	4	1	1	2	All	Active	A & B
Total	33	10	6	17	10 mothers, 5 fathers, 11 children	5 active, 5 terminated	

Table 3. Assessment of outcome and use of SRS and ORS

	Therapy	SRS/ORS	Total
Helped/useful	Family nr. 1,2,3,4,6,9,10	Family nr. 1,3,4,6,8,9,10	7/7
Not helped/not useful	Family nr. 7,8	Family nr. 2	2/1
Uncertain/ambivalent	Family nr. 5	Family nr. 5,7	1/2
Total	10	10	10

Table 4. The therapists: Number of meaning units

Therapist A	Therapist B	Therapist C	Therapist D	Total
83	61	39	26	209

Table 5. The families: Number of meaning units

F1	F2	F3	F4	F5	F6	F7	F8	F9	F10	Total
49	27	26	19	23	35	19	21	32	25	276

Table 6. Therapists: Number of core ideas

Therapist	Therapist A	Therapist B	Therapist C	Therapist D	Total
Therapy	49	27	17	17	110
SRS/ORS	84	69	37	21	211
Total	133	96	54	38	320

Table 7. Families: Number of core ideas

Families	F1	F2	F3	F4	F5	F6	F7	F8	F9	F10	Total
Therapy	40	52	47	33	51	86	35	48	94	91	577
SRS/ORS	62	36	51	28	58	8	15	14	18	14	304
Total	102	88	98	61	109	94	50	62	112	105	881

Table 8. Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields (Elliott, Fischer & Rennie, 1999, p. 220)

A. Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches

1. Explicit scientific context and purpose
2. Appropriate methods
3. Respect for participants
4. Specification of methods
5. Appropriate discussion
6. Clarity of presentation
7. Contribution to knowledge

B. Publishability Guidelines Especially Pertinent to Qualitative Research

1. Owning one's perspective
2. Situating the sample
3. Grounding in examples
4. Providing credibility checks
5. Coherence
6. Accomplishing general vs. specific tasks
7. Resonating with readers

Appendix 2: Information for participants

The therapists:

Letter of information for the therapists of the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud, HF.

For 2 ½ years we have used the measures; Outcome Rating Scale (ORS), Child Outcome Rating Scale (CORS), Session Rating Scale (SRS) and Children Session Rating Scale (CSRS), as clinical aids and as tools for quality assurance of the work of our unit. This work has constituted the start point for the project: Client-directed, outcome-informed therapy in an intensive family therapy unit. The first part of this project is to interview therapists working in the unit. The superior aim of the project is to investigate the practice of using these measures in our unit. The research question to be investigated in this part of the project is: What experiences do individual therapists have with the use of these tools?

In our conversation I would like to focus on your experience of and with these measures. My goal is that this be a conversation in which you tell me as much as possible about your experiences, and from which I can acquire the best possible understanding of these. This means that I am asking permission to ask you questions, but also to bring forth the understanding that develops for me during our conversation so that I can check if this understanding is in accordance with yours. This means that I ask to be allowed to stop the conversation when I do not understand or where there is something that I need to explore more deeply in order to get a better understanding of it.

The focus of this conversation is the Family Unit's use of the measures. I am after the experiences that you have with these measures, that is; all that happens in connection to the concrete use of them in conversations with clients and the results of this use. What can you tell me about how it is to use/administer them and what do you experience when persons fill them out and you start a conversation about this? What do you experience as useful in the concrete conversations in which they are used? Further, I am interested in where this use leads you. Where does it lead in the

individual case? Do the measures have any significance beyond the individual case? Have you experienced something of value that can be transferred to other cases and your activity as a therapist in general? Over time, what do you experience as useful and if possible not useful? This means that I am interested in knowledge and understanding about all aspects that have significance or lack of significance concerning these measures and their use.

In addition I want to know as much as possible about how you experience the fit this use of the measures has with, or does not have with, your thinking about and understanding of the clinical practice of the Family Unit specifically and therapeutic work in general.

The next part of the project will be to interview a selection of our service users, i.e. mothers, fathers and patients, about their experiences with our practice with these measures. In connection with this it is important for me to get to know any question that you think will be important to ask our service users.

I am asking for 2 hours for our conversation. If it appears that we need more time, I ask for the possibility to have one or more further conversations with you.

All participation is voluntary and you can withdraw from this collaboration whenever you want without this having any consequences for you of any kind. I will not use any of the information you give without your permission. Information that I am not allowed to use will immediately be erased.

There is no compensation following participation in this project.

The information I receive will be made anonymous and be treated confidentially. I must have an overview of who I am interviewing, but I will see to it that only I can couple the interview material to each person through a coding system that is kept separate and secured.

I ask for permission to record the interview. The recordings will be kept until 6 months after the project is terminated, and they will be kept secured.

The project has been approved by the Regional Committee for Medical Ethics, South-Norway, and Norwegian Social Science Data Service. The project is financed by the University College of Buskerud.

If you have questions you can contact me in my regular work hours at the Family Unit, through the internal e-mail system of the unit, phone: 91706211 or e-mail; rosundet@online.no.

In advance, thanks for your help!

With friendly regards

Rolf Sundet

Research fellow/clinical psychologist

The parents:

To

Earlier and present service users of the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud HF. Invitation to participate in a project of evaluation; Client directed, outcome informed therapy in an intensive family therapy unit.

You are/have been service users of the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud HF. In our contact, we have used two measures. One sought to give us information about how each treatment session was or functioned for you, and has been a tool for us to find out if we managed to create a good collaborative relationship with you. The second measure sought to give us information about the outcome of our work, that is; if we actually were helpful to you.

We have called our project: Client directed, outcome informed therapy in an intensive family therapy unit. The use of the measures is part of the development of a practice in which each service user gets to direct how our help is organized and performed. Research shows that a high degree of service user participation through concrete feedback from each service user to therapists about how the collaboration functions and whether the therapists actually are helpful is decisive in getting a good treatment result. The interview that we are asking you to take part in will play a conclusive part in how we will develop this work further. Are we on the right track? Was there anything around the use of these measures that was useful/not useful? Is there something we should do differently?

We would now like to evaluate our work with special attention to these two measures, and ask, with this letter, whether it would be possible for the undersigned to interview you (mother, father, child/children) about your experiences with our work in relation to these two measures. It is important for us to get to know how you have experienced our work, if we were helpful and if the use of the measures contributed to us being helpful. We are concerned with gathering information that can help us

create a practice that supports good collaboration and increases the probability of our being helpful for children and their families. Specifically we would like to know more about the two measures and your experiences with their use. Further, we would like to have advice from you concerning this.

We ask for the opportunity to set aside two hours with each family for our conversation. If it should appear that we need more time, we ask for the opportunity to have another conversation with you. As a starting point we may want to talk to each of you separately. The reason for this is that it will be easier for me to keep an overview of each person's answers, but if you should want to have this conversation together this is fully possible.

All participation is voluntary and you can withdraw from this collaboration any time without this having any consequences for you of any kind. I will not use any of the already given information without your permission. Information that I am not allowed to use will immediately be erased

No form of remuneration follows participation in this project.

The information I receive will be made anonymous and treated confidentially. I must have an overview of those I have interviewed, but will see to it that only I can couple the data from the interviews to a particular person through a coding system that will be kept separate and locked up. I ask to be allowed to record the interview. The recordings will be kept half a year after the research project is finished, and they will be kept safely secured.

The project is approved by the Regional Committee for Medical Research Ethics and the Norwegian Data Service for Social Sciences.

The project is financed by the University Collage of Buskerud.

I will contact you by phone approximately one week after you have received this letter to inquire if you would like to participate in this, and, if you say yes, make an appointment for the interview.

If you have questions before this please contact me on my phone, 91706211 or by

E-mail: rosundet@online.no

Beforehand thanks for all help.

Yours sincerely

Rolf Sundet

Research fellow/Clinical psychologist

The children:

Information about the talks at the Family Unit about our cross-off forms

To

.....

You are having or have had a stay at the Family Unit. At the Unit we gave you some sheets or forms. One had questions about how you had been doing since the last time you filled it out. The other had questions about whether we listened to you, consulted you about what we should talk about, did this in a manner that you liked, and lastly, what you thought about what we did together overall. On both of these sheets you answered by putting a cross on a line for each question. We used these sheets to try to find out what you thought was helpful for you and your family, and if we did this in the way you thought we should.

Now we are wondering about what both those who are with us now and those who have been with us earlier, think about these sheets and the way we use them. We are very curious about whether those of you who have used them, think that there are some useful points in using them, whether you think they are not so useful, or maybe that you do not have any opinion at all about the sheets. Because all of us at the Family Unit are curious about this, I will be trying to find out what some of those who are or have been with us think about them and the way we use them. The reason for this is that we want to know as much as possible about how we can be helpful to the children and adults who stay with us. When we get to know this, we think that we might become even better at being helpful for new families that come to us.

As you are or have been with us and used the sheets, I wondered if I could have a conversation with you about what you think and mean about them and the way we used them. Usually, at the Family Unit, we have conversations in many different ways. One is that you just tell me what you think and mean. If you feel that is difficult, then another way is that I ask some questions about the sheets. But sometimes it is also difficult to answer questions, so we will see if there are other ways that we can have a conversation together. We may have to find this out together. What is important is that if you do not want to say something or want to finish the conversation, then you can do this whenever you want.

I will record the conversation. I do that because instead of trying to remember everything that is said, I can listen to the recording of what you have said. I can also copy it and read it afterwards. I will use this to write about what children and parents think about the sheets and our way of using them. Other people that work on helping children and parents can read this, and they can start to do it in the way that you and others describe. This means that I will write about what you are telling me, but no one will know that it is you that has told me this. Who has said what will be kept secret. When I have completed work on the recordings, I will erase them so that no one can listen to them after I have finished with them.

If there is something you wonder about, you can ask your mother or father to telephone me at 91706211 or send an e-mail to me. My address is:
rosundet@online.no

With friendly greetings

Rolf Sundet
Research fellow/clinical psychologist

Appendix 3: Declarations of consent

Therapists:

Declaration of consent

I _____

Employed at the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud today _____ have received information about the research project Client directed, outcome informed therapy in an intensive family therapy unit, led by Rolf Sundet.

I give my consent to be interviewed about my experiences with the use of the measures SRS/CSRS and ORS/CORS and the place and significance this use has in the treatment program of the unit.

I agree to be interviewed more than once if necessary.

I have understood that I can withdraw from further participation without having to give an account for the cause and that there will be no consequences for me if I choose to withdraw.

I have understood that participation in the project does not entail any form of compensation.

I have been informed that identifiable aspects of the material will be omitted and the material will be treated confidentially.

I have read through and understood the above.

Date and signature

Family members:

Declaration of consent

I, _____

have received information about the research project Client directed, outcome informed therapy in an intensive family therapy unit, lead by Rolf Sundet.

I give my consent to be interviewed about the Family Unit's use of SRS/CSRS and ORS/CORS and the experiences I have had with these, the way in which they were used and the place and significance of this manner of use within the treatment program of the unit.

I agree to be interviewed more than once if necessary.

I have understood that I can withdraw from further participation without having to give an account for the cause and that this withdrawal will have no consequences.

I have understood that participation in the project does not entail any form of compensation.

I have been informed that identifiable aspects of the material will be omitted and the material will be treated confidentially.

I have read through and understood the above.

Date and signature

Children

Declaration of consent

I.....

have been told about the research project Client directed, outcome informed therapy in an intensive family therapy unit, led by Rolf Sundet.

I say yes to be interviewed about the scales that we used when I was at the Family Unit. This means that I say yes to talk about what I think about the scales, what we did with them and how they fitted together with the other things we did at the Family Unit.

I say yes to be interviewed more than once if necessary.

I understand that I can say no to being part of this at any time without having to tell why and that nobody can say anything about that afterwards.

I have understood that I can withdraw from further participation without having to give an account for the cause and that this will have no consequences.

I have understood that I will not get anything for being part of this.

I have been told and I understand that what I say will be kept secret.

I have read through and understood the above.

Date and signature

Appendix 4: Interview guides

Interview guide for the interviews with the therapists of the Family Unit.

Project: Client directed, outcome informed therapy in an intensive family therapy unit.

Project leader: Rolf Sundet

Interview start:

First I wonder if you had any questions about the information letter regarding the project?

The focus of this conversation is, as explained in that letter, your experiences with the use of SRS/CSRS and ORS/CORS, and the clinical practice connected with use of these measures. I am wondering if you could start by telling me something about what you are most engaged with at the moment concerning these measures so that I can understand more about your relationship with them.

Administration of the measures

How is using these measures?

- introduction?
- technical problems/difficulties/comprehensibility?
- special positive aspect of the use?

Discussion/interpretation of service users' completion of the measures

Can you describe what you do after the service users have answered the two measures?

How do you relate to SRS/CSR? How do you relate to ORS/CORS?

- dialogues that develop?
- your own focus/concerns?
- use of the graphs and how?

What are your experiences about where this leads?

- the service users' own reactions to their own answers?

- difficulties
- positive/usefulness
- especially important for you?

The effects of the use of the measures

Can you tell me a bit about what you think are the main effects of the use of these measures?

Where has the work with these measures brought you?

Have you noticed changes in the unit that can be ascribed to the use of these measures?

Do you have any stories concerning your use of the measures that have been significant for your further work with these, both specifically and with regard to therapy in general at the unit?

What is helpful in therapy?

We have now talked about the measures. I was wondering if you could tell a bit more about your experiences with what is helpful or effective in therapy more generally?

What are your concerns? Is there something special that you seek to manage in your work? Is there something special that you have experienced as effective or useful?

Thoughts about therapy

One area I am interested in is whether or not the use of SRS/CSRS and ORS/CORS has influenced your manner of thinking about therapy?

Is there something that has been central for you concerning therapy that has been confirmed through the use of these measures?

Can you describe any changes in your manner of thinking about your practice as a consequence of your experiences with the measures?

The future work of the unit

Given the experiences that you have had with the measures and given what we have talked about today; do you have any thoughts that are important for the unit in the future?

Do you have thoughts about how the work with the measures should/must/ideally could be developed further?

The understanding of the interviewer

Let me be allowed to recapitulate some of what you have said.....

Have I understood you correctly?

Is there something you think we should cover more thoroughly in order for me to create a good and adequate understanding of your experiences?

Questions concerning the interview of the service users

My next step will be to interview a group of our service users. Are there questions that you would like to have answered concerning their experiences with the use of the measures and our practice in general? Are there questions you would like me to pose?

Additional comments

Before I say thank you, I would like to end by asking if there is anything you would like me to add or other topics you think are important to talk about that will ensure that I have heard all the important experiences and that I have understood them?

Is there something that emerged during this conversation that has engaged you and that you have not spoken about?

Interview guide for the interviews with the parents

Project: Client directed, outcome informed therapy in an intensive family therapy unit.

Project leader: Rolf Sundet

Interview start:

First I wonder if you have any questions about the information letter about the project?

The focus of this conversation is, as explained in the letter, the experiences each you had with the work of the Family Unit and especially the use of SRS/CSRS and ORS/CORS (*show them the measures and explain/retell what they seek to tell about*). Let me begin with the measure that we call ORS/CORS. Was a graph drawn with you? (*Show them the graph form and give an interpretation/understanding concerning results given a particular graph*).

Given my description of your graph, how different or similar is it with your experience of the work at the unit and the result of this work?

The use of the measures: administration and use

How is/was use of these measures?

- aspects of use (not clear, negative, incomprehensible, disturbing, difficulties)

Did you experience any problems concerning how they are constructed?

Do you think that there is something we could do to improve them and our use of them?

Effect of use

You have told me that you think these measures are useful/not useful and that they are helpful/not helpful.

Could you help me understand what it is about them and their use that was helpful/not helpful and/or significant/not significant?

What was it that happened that was helpful/not helpful? Was it something you yourself did or some of your family members? In that case what was it that was done and what words would you use that best would describe this?

If it was something done by the therapists, what was it and what words would you use that best describe this?

Effects of contact with and/or the stay at the Family Unit

Can you say anything about how you experienced the work of the family unit?

What was helpful/not helpful?

Did the work have any results and effects for you?

If you did not experience any results, could you tell what was missing in what the Family Unit had to offer?

Can you think about any of the changes or lack of change that you have told about and comment on whether or not our use of the measures had any significance for this?

Further development of the work of the unit

Do you believe it is important/not important that the unit uses the two measures?

Should we continue with this?

We have called our project; Client directed, outcome informed therapy in an intensive family therapy unit. Is this a good motto or a good vision for the work of our unit?

Are there problems that you experienced with this and if so which?

Is there something about the use of the measures that results in other important aspects, areas or themes being displaced or not coming into focus?

Are there areas that you think it is important for therapists to devote more attention than we have done up until now?

What do you miss the most?

Questions brought up in the interviews

(Make a guide after the interviews with the therapists).

The understanding of the interviewer

Let me be allowed to recapitulate some of what you have said.....

Have I understood you correctly?

Is there something you think should be covered more thoroughly in order for me to create a good and adequate understanding of your experiences?

Additional comments

Before I say thank you, I would like to end by asking if there is anything you would like to add or that you think is important to tell about that will ensure that I have gotten all the important experiences and that I have understood them?

Is there something that emerged during this conversation that has engaged you and that you have not spoken about?

Interview guide for the interviews with the children

Project: Client directed, outcome informed therapy in an intensive family therapy unit.

Project leader: Rolf Sundet

Interview start

First is there anything you would like to ask about the conversation we are about to have?

Do you know what we shall talk about and do you have any questions about it?

Do you remember the two scales with different lines on that we used to make marks on?

Effects of contact with and/or the stay at the Family Unit

Can you tell me what you especially remember about the scales?

Can you tell me what you think about filling them in?

What did you think about them then and what do you think today?

Was it helpful or not helpful to make marks on them?

The use of the measures: administration and use

Was it possible to understand these scales?

Do you think it was easy or difficult to fill them in?

Could we have made them different?

Effect of use

You have told me that you thought they were helpful/not helpful

Can you help me understand what it was about them and their use that was helpful/not helpful?

What was it that was helpful/not helpful? Was it something you did yourself or something your parents did? In that case what was it that was done? Do you think you could describe it for me?

If it was something the therapists did, what was it and do you think you could describe it for me?

Effects of contact with and/or the stay at the Family Unit

Did you like/not like being and working at the Family Unit?

What was helpful/not helpful?

What words would you use to tell me about what was useful/not useful?

What were the results of the stay and work at the family unit do you think?

Further development of the work of the unit

Do you think we should continue or stop using the two scales?

Is there something we should do instead of using them?

Was there something we should have done differently?

Did you miss something at the Family Unit and what do you miss the most?

Questions raised by the interviews

(Make a guide after the interviews with the therapists).

The understanding of the interviewer

Let me be allowed to retell some of what you have told

me:.....

Have I understood you correctly?

Is there something you think we should talk more about in order for me to understand you better?

Additions and others

Before I say thank you, I would like to end by asking if there are other things that you think are important to tell about in order for me to be certain that I have gotten all the important experiences you had at the unit and that I have understood them.

Is there something that came to mind during this conversation that that you have not spoken about?

I

**COLLABORATION: FAMILY AND THERAPIST PERSPECTIVES OF
HELPFUL THERAPY**

Rolf Sundet, Department of Health, University College of Buskerud, Norway.

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The author wishes to thank Professor Sissel Reichelt for her valuable feedback and support.

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ABSTRACT

This qualitative study examined how a group of families and their therapists described helpful therapy. The qualitative analysis generated family and therapist perspectives. As a double description, the therapist- and family perspectives highlighted conversation, participation and relationship as three core areas of helpful therapy. These are specified by categories and subcategories that center upon activities of sharing experiences, contributing own knowledge and personal involvement, posing questions, reformulating and giving feedback, and specifying the therapeutic relationship as a relationship of collaboration. Discussion of similarities and differences between the perspectives provides a description of what constitutes good therapy for the families and therapists and points to expansion of the models that have guided the therapists.

II

COLLABORATION: WORKING WITH PROCESS AND OUTCOME

Rolf Sundet, Department of Health, University College of Buskerud, Norway.

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The author wishes to thank Professor Sissel Reichelt for her valuable feedback and support.

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E-mail: rosundet@online.no

ABSTRACT

The aim of this study is to explicate how families and their therapists evaluate and describe the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work. The study is qualitative using a modified grounded theory approach. Results confirm the feasibility of these scales as conversational tools although some difficulties and disturbances were identified in relation to both. The family perspective identified four conversational processes and the therapist perspective identified six conversational types. A suggested generalization is that all the measurements and tools applied in clinical practice in principle can be seen as therapeutic tools especially useful for establishing conversations and strengthening collaboration between service users and therapists.

III

**Therapeutic collaboration and formalized feedback: Using
perspectives from Vygotsky and Bakhtin to shed light on practices in
a family therapy unit.**

Rolf Sundet

Buskerud Hospital and University College of Buskerud, Norway

Word count: 6676

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ABSTRACT

Patient-focused research points to the necessity of continuously monitoring process and outcome in psychotherapy, supplying service users and their therapists with feedback as a way of avoiding no-change and detrimental development. At the Department of Child and Adolescent Mental Health, monitoring is implemented in an intensive family therapy unit inspired by postmodern and language oriented forms of family therapy using two scales, the Session Rating Scale and the Outcome Rating Scale. Research-generated descriptions of users' experiences of these scales as conversational tools are reflected upon through concepts from the work of Vygotsky and Bakhtin. Mediation, dialogicality, voice, the zone of proximal development and the metaphor of scaffolding are offered as conceptualisations that expand the inspirational sources of the unit by creating and enhancing further possibilities for collaboration between families and their therapists.

KEYWORDS

patient-focused research, feedback, conversational and conceptual tools, collaboration